East Toronto Health Partners

Evaluation of Winter Surge Initiatives

2019-2020

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The evaluation team wishes to thank the project leads and frontline staff who took the time to share their experiences and insights with us.

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EXECUTIVE SUMMARY

The Challenge

Emergency departments (ED) routinely struggle to maintain capacity during the winter flu season. This is exacerbated by health care providers often reducing their hours and services during the holidays. As a result, more people are funneled to EDs, leading to overcrowding, hallway medicine and suboptimal care. Ontario's health system needs better ways of dealing with winter flu season and the associated surge in demand for services. One approach being explored is for hospitals and local health organizations to work collaboratively to more effectively deal with the winter surge. How can community-based approaches help maintain critical capacity, support needs in the community and alleviate hallway medicine?

ETHP Winter Surge Initiative

Building on last year's winter surge initiative, the East Toronto Health Partners (ETHP) brought together over 30 of its Engaged Partners in August and September 2019 to develop proposals on how to maintain critical capacity during winter surge. A timeline of the planning process is shown below.

Out of this process, 25 projects were approved for funding. These projects were grouped into four categories:

1. Improve wellness and divert from hospital — 12 projects
2. Help address broader community pressures — 5 projects
3. Reduce time in ED and avoid admissions — 5 projects
4. Transition patients home more effectively — 3 projects

Of these, 15 projects were selected for evaluation.[1] Eight of these were "Summary" evaluations while seven were "Deep Dive" evaluations.[2] A list of the evaluated projects can be found on the next page.

Evaluated projects typically lasted between 12-18 weeks but varied widely (from 2 days to 21 weeks). All projects ran between end of October and the end of March. The funding allocated for these projects was approximately $1M. Due to the nature of the surge funding, all projects ended by March 31.

[1] Projects not selected for evaluation were "in-kind" projects where no surge funding was provided or were projects where MGH felt there was no need for evaluation (e.g., Home2Day, which had been evaluated last year). In addition, one project originally selected for evaluation was not evaluated as it was scheduled beyond the surge period.

[2] Summary evaluations provide a general assessment based on data provided by the project team and interviews with project leads. Deep dives are more comprehensive assessments involving additional data collection by the evaluation team.

Table 1: List of Evaluated Projects

Project	Organizations	Duration	Budget
Community Transport Project	South Riverdale Community Health Centre (SRCHC) / Harmony Hall; Michael Garron Hospital (MGH)	January 6, 2020 – March 31, 2020 (12 weeks)	$40,000
Committed Non-Emergent Patient Transport (NEPT)	MGH; Spectrum Transportation	November 4, 2019 – March 31, 2020 (18 weeks)	$40,000
East Toronto CHC Network Community Flu Clinics	East End Community Health Centre (East End CHC); SRCHC; Access Alliance; Flemingdon Health Centre / Health Access Thorncliffe Park (HATP)	November 15, 2019 – February 19, 2020 (13 weeks)	$50,000
East Toronto Mobile Flu & Fall Clinic	VHA Home Healthcare; WoodGreen Community Services; Toronto Community Housing Corporation (TCHC)	November 23, 2019 – February 2020 (12 weeks)	$50,000
Fast Access to Rehab	Providence Health Care / Unity Health; MGH	November 1, 2019 – March 31, 2020 (18 weeks)	$53,000
Health Boost Initiative	Warden Woods Community Centre (WWCC); Afghan Women's Association; East End CHC	January 7, 2020 – Mid-March 2020 (9 weeks)	$25,000
Homecare Specialist	VHA; MGH; Spectrum Health Care	January 7, 2020 – March 9, 2020 (9 weeks)	$260,000
Paediatric Short-Stay Unit (PSSU)	MGH	November 11, 2019 – Mid-March, 2020 (18 weeks)	$36,000
NICE Hospital Fund	MGH	October 31, 2019 – March 31, 2020 (21 weeks)	$75,000
NICE Community Fund	WoodGreen	January 31, 2020 – March 3, 2020 (5 weeks)	$30,000

Prevnar13 Surge Project	Dr. Michael Chu; MGH; Pfizer Canada	January 6, 2020 – March 28, 2020 (12 weeks)	$50,000
Mental Health Surge Project	Seamless Care Optimizing Patient Experience (SCOPE) / East Toronto Health Partners (ETPH)	December 18, 2019 – March 28, 2020 (14 weeks)	$60,000
Oakridge Health and Harm Reduction Hub	Agincourt Community Services Association, Cota, Comprehensive Treatment Clinic, Inter-Professional Team/Unity Health, MGH, SRCHC, St. Michael's Homes, WWCC	February 4, 2019 – April 17, 2020 (10 weeks)	$117,000
Thorncliffe Park Winter After-Hours Clinic	HATP, Toronto Healthcare Centre, MGH, Dr. Michael Chu	December 2, 2020 – March 7, 2020 (14 weeks)	$112,000
Walk-In Counselling during "12 days of Holidays"	WoodGreen	December 23 & December 30, 2020 (2 days)	$3,000

CORE LEARNINGS

Assessments for each of the projects, along with key metrics, outcomes, and learnings, are provided in the evaluation report. Each assessment begins with a brief description of the intervention and project goals, followed by a summary of what happened during the project. Key outputs are then provided, followed by findings and recommendations for that project.

Beyond the individual project assessments, several cross-cutting themes emerged during the evaluation. These represent common learnings for the winter surge initiative as a whole. These **core learnings** apply across projects and can be summarized as follows:

Theme 1: Projects with specific, achievable goals performed better

- Projects with specific objectives were able to proceed from proposal to implementation more smoothly than projects with vague goals
- Proposals often specified goals that could not be realistically achieved within the funding period; ensuring proposed activities are feasible would reduce delays in project launch

Theme 2: Rescoping of projects needs to be done carefully

- A number of projects changed substantially between the proposal stage and implementation
- While it may make sense to rescope a project in certain circumstances, this should be done purposefully as additional time will be needed to make adjustments, impacting the start date
- A clear process is needed for engaging all stakeholders (e.g., funders, executive sponsors, project leads, front-line staff) when a decision is made to rescope a project

Theme 3: Missed opportunities for integration and partnership between projects

- Multiple projects had similar activities that could have benefited from coordination and integration
- While some groups were encouraged to work together, this did not end up happening
- Establishing mechanisms to support partners in collaborating could lead to integrated projects that have greater impact and better meet community needs

Theme 4: Project management is a key success factor

- Projects that had a designated project manager tended to run smoother, be more strategic, and have activities that were aligned with the project's stated goals
- However, many projects did not have a designated project manager, including those projects that experienced the most problems in terms of design and implementation
- Project management is crucial to ensuring individual projects run smoothly
- A dedicated project manager would also benefit the overall Surge initiative

Theme 5: Few projects took advantage of the opportunity to learn from evaluation

- Many of the project leads were unclear on the purpose of the evaluation, who was carrying out the evaluation, or how the evaluation was meant to be used as a learning opportunity
- Projects that did engage with the evaluation team early on were able to deliver reliable and targeted data and provide more substantive feedback
- To maximize learning, projects should collect metrics that are specifically geared to evaluating the project's goals and anticipated outcomes
- Clear expectations need to be conveyed from funders and executive sponsors to project leads regarding their responsibilities in terms of data collection and evaluation

CORE RECOMMENDATIONS

The high-level learnings above lead to the following core recommendations, which address three crucial aspects of program development and delivery: design, implementation and evaluation.

Design

More attention is needed at the proposal stage for both projects and funders.

Encourage projects to be narrow and specific in their aims

- Projects with specific aims tended to perform better

MGH should hire a project manager to specifically oversee Surge initiatives

- A dedicated project manager to oversee the Surge initiatives could support partners in developing and implementing interventions and serve as a central point of contact and accountability

Encourage partnership/integration between similar projects

- Collaboration could help meet needs more systematically and broaden the impact of projects

Implementation

Careful attention to implementation is needed for projects to run smoothly and have the greatest impact.

Pro-actively address discrepancies between proposal and implementation plans

- This will help prevent project drift and scope creep

Projects should hire a project manager, if possible.

- At a minimum, projects should clearly identify a project lead who will be responsible for ensuring smooth implementation

Ensure leadership are committed and engaged

- Oversight by organization leaders is crucial to ensuring successful implementation

Evaluation

More effort is needed to support meaningful evaluation.

Clearly communicate expectations around evaluation to project leads and sponsors

- Not all projects understood the purpose of evaluation and most projects did not take advantage of the evaluation as a learning opportunity

Identify project-specific metrics for all projects

- This will enable meaningful evaluation and improvement over time

Require project leads to make early and frequent contact with the evaluation team

- Early and frequent contact allows for quick identification and solving of potential problems

PROJECT RECOMMENDATIONS

Outcomes and recommendations for each project are summarized below. In terms of outcomes and results, projects fell into one of four categories:

Successful: Program goals met

- East Toronto CHC Network Community Flu Clinic
- East Toronto Mobile Flu and Falls Clinic
- NICE Hospital Fund
- Prevnar13 Surge Project
- Oakridge Health and Harm-Reduction Hub
- SCOPE Mental Health
- Thorncliffe Park Winter After-Hours Clinic

Mixed Results: Some program goals met but one or more major issues identified

- Committed Non-Emergent Patient Transport
- Fast Access to Rehab
- Health Boost Initiative
- Walk-in Counselling During "12 Days of Holidays"

Unsuccessful: Program goals not met

- Community Transport Project
- Paediatric Short-Stay Unit

Unclear: Data unavailable to properly evaluate program

- HomeCare Specialist
- NICE Community Fund

High-level project recommendations are provided in Table 2. These recommendations are based on whether project goals were met, how well the project addressed surge priorities, patient and client experience (where available), cost, and partnership building (if applicable).

Detailed recommendations for each project can be found in the main report.

Table 2: Project Assessments and Recommendations

Project	Outcome	Result	Recommendation
Community Transport Project	70 evening transports provided for moderate mobility needs Very low utilization, despite evidence of need	Unsuccessful	Coordinate all transport programs and clarifying referral criteria to increase efficiency and impact
Committed Non-Emergent Patient Transport (NEPT)	466 trips conducted >80% were one-way trips to residences and lower utilization for transport between facilities.	Mixed results	Conduct a needs assessment prior to renewal to determine what types of transportation need are highest
East Toronto CHC Network Community Flu Clinics	50 clinics held and 662 flu vaccines administered to children and adults	Successful	Develop a coordinated approach with all flu clinic programs to increase impact
East Toronto Mobile Flu & Fall Clinic	10 clinics held, 112 flu vaccines administered and 76 OT assessments complete	Successful	Develop a coordinated approach with all flu clinic programs to increase impact
Fast Access to Rehab	258 referrals to Providence rehab programs from MGH ED, a 30% increase year-over-year Unable to sustain relationships with SCOPE primary care, which was the main goal of program	Mixed results	Develop a focused engagement strategy to connect with primary care physicians and SCOPE team
Health Boost Initiative	7 health promotion events, 49 individuals	Mixed results	Would benefit from clearer goals and better implementation to achieve broader community impact
Homecare Specialist	69 individuals received services 10 were home settlement or transport only 59 received PSW &/or Rehab and 29 received follow-up LHIN services	Unclear	Incorporate role in a redesigned and integrated transition-home process Look at successful integrated transition-home models at other hospitals
Paediatric Short-Stay Unit (PSSU)	92 patient encounters over 96 clinic days	Unsuccessful	Conduct a full needs assessment before implementing another pediatric-focused initiative to address ED pressures

NICE Hospital Fund	56 patients provided with support to facilitate return to the community Most common requests were walkers and PSW care	Successful	Extend program year-round Link with other NICE funds (Primary Care & Community)
NICE Community Fund	At least 30 individuals provided with support Most requests for food security, transport and care services	Unclear	Ensure clear processes and potential partners are organized prior to start of program Link with other NICE funds (Primary Care & Hospital)
Prevnar13 Surge Project	356/500 doses of Prevnar 13 administered 60/200 providers whom the EasT-FPN was trying to actively engage in the network placed orders	Successful	While successful, the program does not need to run next year as the target population would have access to Prevnar through ODB
Mental Health Surge Project	113 patients accessed the services 299 free sessions held 59 physicians used the program	Successful	Explore ways to extend program throughout the year
Oakridge Health and Harm Reduction Hub	311 harm reduction client encounters, 60 one-on-one sessions provided Hub location, programs and services established	Successful	Continue efforts to encourage collaboration between partners and engage local community Assess need for continued funding
Thorncliffe Park Winter After-Hours Clinic	846 patients seen 95 clinic days 26 patients referred for rostering	Successful	Adjust operation to align with patient demand and increase direct outreach to non-English speaking individuals
Walk-In Counselling during "12 days of Holidays"	10 individuals provided one-on-one counselling 10/30 counselling slots filled	Mixed results	Redesign and expand program so that it addresses community needs throughout the entire holiday period

EVALUATION REPORT

INTRODUCTION

As part of its preparation for the annual winter flu season, East Toronto Health Partners (ETHP) brought together over 30 of its Engaged Partners in August and September 2019 to discuss ideas on how to maintain critical capacity during winter surge.

Through a collaborative, iterative approach, the group planned a set of "community surge" initiatives to reduce "hallway health care" and support community needs. This builds on the successful winter surge initiative that ran in 2018-19.

A total of 25 projects were approved for funding. These programs were intended to help address winter surge through a variety of interventions. Start dates for projects varied. All programs ended by March 31, 2020.

While most projects had wrapped by early March, the final weeks of some programs may have been disrupted by COVID-19.

At the request of Michael Garron Hospital (MGH), an evaluation was conducted. The goal of the evaluation was to support learning in each of the surge projects, as well as capture learnings across projects.

This report summarizes what we learned from this year's community surge initiatives. In consultation with MGH, it was decided the evaluation report would provide a high-level summary of each project, along with more in-depth analysis of certain priority projects.

METHODS

Interviews were conducted with the lead(s) of each project. Initial interviews were conducted with project leads who responded to requests and follow-up messages sent by the evaluation team. All project leads participated in exit interviews.

- Purpose of start interviews was to review key information about projects and help leads think about what data they would need to collect for evaluation
- Purpose of exit interviews was to provide an opportunity reflect upon the project and lessons learned, and to answer questions that arose during the course of the evaluation

Two types of evaluation were conducted, based on priorities identified by the funder:

- 'Deep Dive' evaluations aimed for a comprehensive assessment of the project's impact. This was achieved through collaboration with the project team, qualitative data collection, and analysis of quantitative data that was collected by the project team through strategies co-developed with the evaluation team.
- 'Summary' evaluations offer an overview of project activities based on quantitative data provided by the project team and interviews with project leads and staff. The evaluation team also offered support in designing data collection strategies and conducting analysis.

When possible, data collection plans were developed and carried out in consultation with project leads to complement and expand on data that project leads planned to collect. Deep dive evaluations were prioritized, however projects designated for summary evaluation were provided with similar support when leads expressed interest in using the evaluation as an opportunity for learning.

The additional data was generally qualitative in nature and meant to provide additional context and insight into the project's operations and impact. Methods used to collect this data included:

- Patient and provider surveys
- Interviews with service providers, including frontline staff and executives
- Focus groups with service providers
- Chart and document review
- Observation of meetings and on-site activities

Interviews and focus groups were transcribed and analysed thematically. Consent was obtained whenever collecting data from patients or providers.

Where appropriate, information provided by project leads to MGH was shared with the evaluation team. Requests for additional information were made when the data provided by project leads was insufficient. In some cases, requests for data needed to be escalated to MGH executives.

PROJECTS EVALUATED

Project	Organizations
Community Transport Project	South Riverdale Community Health Centre (SRCHC)/Harmony Hall, Michael Garron Hospital (MGH)
Committed Non-Emergent Patient Transport (NEPT)	MGH, Spectrum Transportation
East Toronto CHC Network Community Flu Clinics	East End Community Health Centre (East End CHC), SRCHC, Access Alliance, Flemingdon Health Centre/Health Access Thorncliffe Park (HATP)
East Toronto Mobile Flu & Fall Clinic	VHA Home Healthcare (VHA), WoodGreen Community Services, Toronto Community Housing Corporation (TCHC)
Fast Access to Rehab	Providence Health Care/Unity Health, MGH
Health Boost Initiative	Warden Woods Community Centre (WWCC), Afghan Women's Association, East End CHC
Homecare Specialist	VHA, MGH, Spectrum Health Care
Paediatric Short-Stay Unit (PSSU)	MGH
NICE Hospital Fund	MGH
NICE Community Fund	WoodGreen
Prevnar13 Surge Project	Dr. Michael Chu, MGH, Pfizer Canada
Mental Health Surge Project	Seamless Care Optimizing Patient Experience (SCOPE)/East Toronto Health Partners (ETPH)
Oakridge Health and Harm Reduction Hub	Agincourt Community Services Association, Cota, Comprehensive Treatment Clinic, Inter-Professional Team/Unity Health, MGH, SRCHC, St. Michael's Homes, WWCC
Thorncliffe Park Winter After-Hours Clinic	HATP, Toronto Healthcare Centre, MGH, Dr. Michael Chu
Walk-In Counselling during "12 days of Holidays"	WoodGreen

Italics indicate 'Deep Dive' evaluations (see 'Methods' on previous page).

DEEP DIVE EVALUATIONS

EAST TORONTO CHC NETWORK COMMUNITY FLU CLINICS

LEAD ORGANIZATION: EAST END CHC

PROJECT LEAD: MIREILLE CHEUNG

DATES: NOV. 15, 2019 TO FEB. 19, 2020

PARTNER ORGANIZATIONS: SOUTH RIVERDALE CHC, ACCESS ALLIANCE, FLEMINGDON HEALTH CENTRE/HEALTH ACCESS THORNCLIFFE PARK

TAKE-AWAYS

1. Community-based flu clinics were implemented on a large scale across East Toronto and successfully reached a wide range of community members
2. Issues to be addressed in future years include providing education about the safety and efficacy of the flu vaccine and ensuring the most vulnerable members of the community are reached (e.g., homebound and non-English speaking individuals)
3. CHCs in East Toronto could further collaborate to fully leverage their unique capabilities and knowledge of the populations they serve

INTERVENTION

- The project provided flu vaccines throughout east Toronto
- The target population was vulnerable and marginalized people
- Partner CHCs provided information about potential locations in their catchment areas and East End CHC scheduled and staffed each clinic
- 50 clinics were set up at these sites; flu vaccines were administered by an East End CHC Nurse
- The original plan included an educational component, but this was not implemented due to time and budget constraints

GOALS

1. Leverage existing partnerships and relationships to offer community flu vaccine clinics to better support vulnerable populations in specific locations identified by/with partners (shelters, seniors TCHC buildings, retirement homes, and other local community agencies)
2. Increase the number of flu vaccines administered to target vulnerable populations in the east end of Toronto
3. Decrease the number of at-risk populations accessing ER services due to influenza-related health problems
4. Increase referral to ongoing primary care and other local services and resources, as appropriate
5. Increase knowledge about the seasonal flu, vaccination and its benefits for vulnerable populations

COSTS

Budget: $50,000
Approximately $1,000/clinic

WHAT HAPPENED

Process

1. East End CHC communicated with partner CHCs to learn about agencies in their catchment areas that serve vulnerable or marginalized populations (e.g., elderly, low income, new immigrants, children, etc.)
2. A Community Outreach Coordinator (COC) employed by East End CHC reached out to agencies identified by partner organizations and East End CHC to inquire about their interest in hosting a flu clinic and find the most suitable dates, times and methods of advertising the clinics
3. The COC and an EECHC nurse traveled to sites to set up and run the clinics
4. Prior to receiving the flu shot, clients completed a form which included medical screening questions and 4 socio-demographic questions (income, race/ethnicity, gender, disability)

Evaluation Activities

Quantitative

- Data provided by East End CHC on the number and location of clinics, vaccines administered, and socio-demographic characteristics were analysed to gain insight into the extent and impact of the initiative
- A survey completed by partners was conducted to understand their perspective and experiences

Qualitative

- To capture additional insights, two semi-structured interviews were conducted in-person with the project lead and Community Outreach Coordinator

Outputs

662 VACCINES ADMINISTERED TO CHILDREN AND ADULTS IN EAST END COMMUNITIES

41 INDIVIDUAL AGENCIES HOSTED AT LEAST 1 CLINIC

50 CLINICS WERE SCHEDULED AND RUN

Clinic Sites

Note: Two clinics north of Highway 401 not pictured

of Vaccines by Agency Type

26 Community organizations (drop-in centres, community centres, churches, etc.)	232
9 Elementary & Primary Schools	359
6 Residences Shelters, TCHC Senior's Buildings Retirement Homes	71

Demographics

Ethnicity	*N (%)*
White	229 (35%)
Asian	213 (32%)
Black	45 (7%)
Middle Eastern	30 (5%)
Latin American	10 (2%)
First Nations	7 (1%)
Other/No data	128 (19%)

Age	*N (%)*
Child (0-17)	214 (32%)
Young Adult (18-39)	129 (19%)
Middle-Aged (40-64)	200 (30%)
Older Adult (65+)	92 (14%)
No data	27 (5%)

Approximately a third of flu shots were provided to children under the age of 18.

FINDINGS

Perceived Outcomes

- The Community Outreach Coordinator, who was on-site for most of the clinics, noted in interviews that there were many positive comments about the convenience of being able to get a flu shot during regular routines (while picking up kids from school, attending a community centre, etc.); this was perceived by the project lead as a key means of engaging the target population
- Staff encountered some difficulties in reaching populations who mistrust the healthcare system and/or are influenced by cultural myths or other disinformation about the flu vaccine
    - The project lead and partner organizations perceived that it would have been beneficial to implement the planned educational component
- Many agencies that hosted clinics reported that it was a positive experience and that they would like to do it again

Project Outcomes

Expected Outcome	*How Did They Do?*
Increase the number of flu vaccines administered to target vulnerable populations in the East end of Toronto.	662 people were vaccinated, of whom a majority were part of a vulnerable or marginalized/minority group with respect to income, disability and ethnicity
Increase knowledge about the seasonal flu, vaccination and its benefits for vulnerable populations	The educational component that was proposed could not be completed
Decrease # of at-risk populations accessing ER services due to influenza related health problems	There is no way of knowing if those vaccinated would have gotten the vaccine if the clinics had not been run; the clinics started relatively late in the season, and the effectiveness of the flu shot diminishes as the flu season progresses; and there was no data linkage to discern whether ER visits were reduced as a result of this intervention
Increase referral to ongoing primary care and other local services and resources as appropriate	Increasing referrals to community services could not be completed as the clinics were too busy to have time for this process
Leverage existing relationships and partnerships to offer community flu shot clinics that target vulnerable populations in specific locations identified by/with partners (shelters, seniors TCHC buildings, retirement homes, and other local community agencies).	Partnerships were leveraged, however the coordination/cooperation between partners was minimal

RECOMMENDATIONS

Should this program run again?

Yes. With increased organizational collaboration this initiative has the opportunity to become more successful each year, with more vulnerable populations reached and more flu vaccine education provided.

If this program were to run again, what changes should be made?

1. Earlier start in the season to maximize effectiveness of flu vaccines
2. More collaboration with partner organizations to ensure the most vulnerable populations have access to the flu shot
3. Implementation of educational component (in coordination with partner organizations) to combat myths and misinformation about the flu vaccine
4. Ensure that data is collected about whether clients were planning to get the flu shot anyway and whether they had gotten it before (lifetime)
5. Access to MGH ER data regarding the number of flu-related visits, for year-to-year comparison
6. Explore opportunities to integrate with other flu-clinic programs in East Toronto

EAST TORONTO MOBILE FLU & FALL CLINIC

LEAD ORGANIZATION: VHA HOME HEALTHCARE (VHA)

PROJECT LEADS: AMBER PROWSE-ZWEGERS, LEAD FOR OCCUPATIONAL THERAPISTS; NAWAL OBAID: PRIMARY LEAD FOR NURSING SERVICES; FRANCES MORTON-CHANG, WOODGREEN

PARTNER ORGANIZATIONS: WOODGREEN COMMUNITY SERVICES; TORONTO COMMUNITY HOUSING CORPORATION (TCHC)

DATES: NOVEMBER 23, 2019 TO FEBRUARY 2020

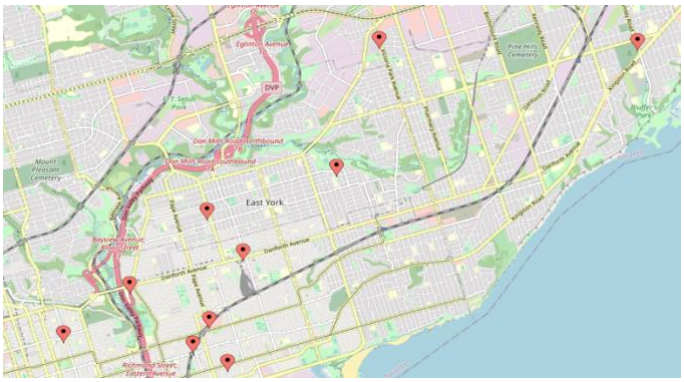
TAKE-AWAYS

1. Mobile flu clinics can provide seniors with convenient access to flu immunizations and immediate occupational therapy assessments
2. Referrals to longer-term LHIN services and community program supports can be put in place to support home safety and independence
3. Strategies are needed to advertise and promote flu clinics as broadly as possible

INTERVENTION

- VHA, WoodGreen and TCHC partnered to identify buildings were there might be a high proportion of homebound seniors who may be unattached to primary care or lacking needed LHIN supports
- A registered nurse (RN) provided flu vaccines and an occupational therapist (OT) was on-site to provide assessments for home safety, mobility and falls risk
- OT assessments were used to connect seniors to additional community supports to address potential safety issues, reduce isolation and improve overall well-being

Flu Clinic Sites



GOALS

1. Provide flu shots for those without primary care physicians who did not receive a flu shot last year, especially those who were homebound
2. Improve home safety environments through risk assessments by OTs
3. Identify and link seniors who could benefit from additional LHIN and community supports
4. Avoid hospital admissions related to flu-related conditions and preventable falls

COSTS

Budget: $50,000 to WoodGreen for VHA and WoodGreen collaboration

WHAT HAPPENED

Process

- Project coordinator from WoodGreen conducted outreach to WoodGreen & TCHC seniors' buildings, scheduled clinics, arranged transportation, and provided administrative support
- RNs and OTs from VHA travelled to seniors' buildings to follow up on referrals, when available, and provide drop-in support by setting up an information table in the lobby
- The RN administered the flu vaccine and completed a program-specific questionnaire covering connection to primary care; where medical attention was usually sought; whether the patient received a flu shot last year; recent fall history and current LHIN service use.
- An OT was available to provide a brief OT assessment of the home environment, equipment needs, physical and cognitive status, access to support, and current living situation.
- The OT provided recommendations for follow up services (community & LHIN based), provided health teaching, reached out to vendors on behalf of the individual and provided direct equipment and home-safety modifications.
    - Referrals for LHIN services were initiated through the VHA OT or through WoodGreen assisted living supervisors
    - Clients were also referred to community services such as WoodGreen programs, Meals on Wheels and Wheel-Trans

Evaluation Activities

Quantitative

- To gain insight into the individuals treated, assessment outcomes and recommendations, a review of the RN and OT documentation was completed

Qualitative

- To capture additional insights, which may not be apparent in the clinical records:
    - Four individual, semi-structured interviews, in person & on the telephone were conducted. These interviews were with each of the with two clinical project leads (2) and two OTs. One focus group was held with four nurses and one OT who worked on the program

Outputs

10 CLINICS RUN

112 FLU SHOTS ADMINISTERED

76 OT ASSESSMENTS COMPLETED

48 LHIN REFERRALS FOR REHAB FOLLOW UP (OT, PT OR SW)

17 REFERRALS TO COMMUNITY SERVICES

6 GP REFERRALS

Data from the brief nursing questionnaire and the clinical documentation was provided for 10 clinics held between November 23 and February 23.

Successful Flu Shot Outcomes

- 30/112 individuals had not received the flu shot last year
- 74 individuals had previously received the flu shot and most often through their family physician

FINDINGS

Reaching Potential Clients

- Offering assessments in the lobby enabled staff to identify clients directly. However, this strategy only reached residents who passed through the lobby when staff were present; language barriers arose in some cases
- Staff reported that it was easiest to identify and reach homebound seniors who already had PSW support or lived in WoodGreen buildings with an assisted-living supervisor
- Reaching people who were not linked to support services was more difficult. Without the pre-existing connection it was believed that opportunities to provide education about the benefits of vaccination and OT assessment were missed
- Further engagement of staff at TCHC and promotional materials in multiple languages were suggested as strategies to broaden the program's impact and ensure it reaches those with the highest levels of need

Referrals & Community Programs

- Immediate LHIN and community program referrals helped streamline access for many of the clinics' clients

Perceived Benefits

Strengthened Interprofessional Teams

- Nurses, OTs and PSWs can work well in collaboration with one another to benefit frail and vulnerable seniors to live in the community and avoid potential visits to the ED

Improved Safety

- Mobility and fall risk assessments were perceived as particularly beneficial because, as one VHA OT put it: "you could see that people needed it"
- The clinics provided real-time opportunities to offer an immediate assessment and simple health teaching or equipment modifications to address fall risk (e.g., loose slippers, loose rugs, mobility equipment repair).

A client who was at risk of falls in the shower had a grab bar funded but not installed. The OT arranged installation to prevent falls.

Awareness of OT Role

- The clinics provided opportunities to extend OT practice to communities who may not have previous exposure or appreciation of the roles and skills they can provide
- OTs are well placed to provide patient advocacy and health teaching to support improved health literacy

At one WoodGreen Seniors Building, an Assisted Living Supervisor referred a 90-year client with a damaged 3-wheeled walker to the clinic. The client did not speak English and a WoodGreen PSW provided translation during the visit. The OT not only assessed the client but provided her with a walker the same day.

Project Outcomes

Expected Outcome	*How Did They Do?*
Increased participation in flu shots from those without primary care physicians who did not receive a flu shot last year, especially those who are homebound	112 individuals received a flu shot this year 30 of them did not get a flu shot last year We are unable to determine how many of these individuals were homebound. Many clients were already attached to primary care.
Increase the number of home safety environment risk assessments by OTs	76 OT assessments were completed
Identify and link seniors who could benefit from additional LHIN and community supports	48 LHIN referrals, 17 community service referrals and 6 referrals for GP linking were made.
Avoidance of hospital admissions related to flu related conditions and preventable falls	Unable to measure directly. In theory receiving a falls risk assessment and a flu shot could help reduce hospital admissions due to flu related conditions or falls.

RECOMMENDATIONS

Additional outreach strategies could broaden the program's impact and ensure clients with the highest level of need are reached consistently.

1. Partnerships with building managers and on-site staff to support early identification of those who may benefit from services
2. Promotion and advertising of the clinics in advance
3. Promotion and delivery of services in languages other than English

NICE HOSPITAL FUND

LEAD ORGANIZATION: MICHAEL GARRON HOSPITAL (MGH)

PROJECT LEAD: LINDSAY MARTINEK

DATES: OCTOBER 31, 2019 TO MARCH 31, 2020

TAKE-AWAYS

1. Demand for this program increased from last year
2. Transition navigators at MGH believe the program is useful and would like to see it extended throughout the year
3. Clearer guidelines and linking/coordinating with other NICE fund initiatives (Community and Primary Care) would amplify the impact of this program

INTERVENTION

- Provide one-time or time-limited funds to facilitate early discharge of patients
- Funds are generally small amounts meant to address simple, low-cost needs
- Targeted to MGH patients who are eligible to be discharged but are unable to leave due to non-medical issues

GOALS

1. Address barriers preventing timely transition back to the community
2. Support safe transitions home
3. Support patient flow
4. Reduce length of stay for patients ready to be discharged
5. Utilize 90%+ of funds

COSTS

Budget: $75,000

WHAT HAPPENED

Process

The process for accessing NICE Hospital funds was as follows:

1. Identify eligible patients (see below)
2. Identify barriers to timely discharge
3. Identify additional support needed
4. Fill out necessary forms and acquire relevant approvals
5. Purchase equipment and/or put in place needed services and referrals
6. Facilitate patients' discharge

These tasks are normally carried out by Transition Navigators (TNs). Sometimes, other hospital staff (e.g., OTs, PTs) will recommend a patient who they believe would benefit from the fund. However, it is up to the TNs to determine if a patient is eligible and to request funds on the patient's behalf.

A flowchart describing the process can be found on the next page.

Identifying eligible patients

- Patients are eligible if they are medically stable to be discharged from MGH
- Aside from this, there does not appear to be formal criteria for identifying which patients should access the fund
- Generally, TNs identified patients based on their clinical judgement
- Other hospital staff can recommend a patient for consideration, but it is up to the TNs to decide
- In interviews, TNs noted that they prioritize "social admits" or those with "social barriers" (e.g., hoarding, family issues, limited financial resources, no place to live, no family)

Evaluation Activities

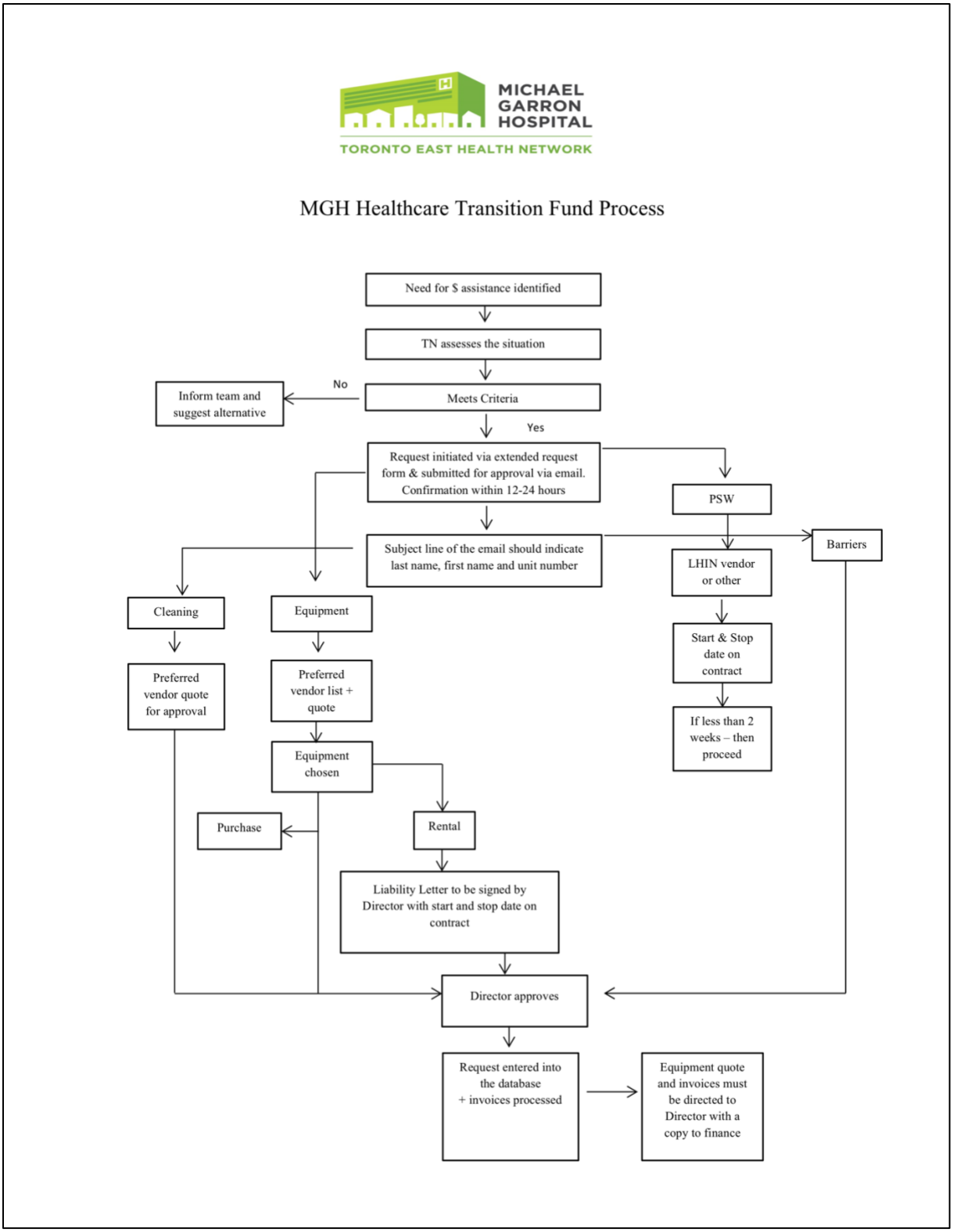
Quantitative:

- To understand how the funds were used, the evaluation team analysed expenditure data and also conducted chart reviews

Qualitative:

- To gain a further understanding of the project's operations and impact, the project lead was interviewed at the beginning and end of the program
- The evaluation team also conducted a focus group with three Transition Navigators to get their thoughts about the impact of the program, challenges they faced, and how they think the program can be improved

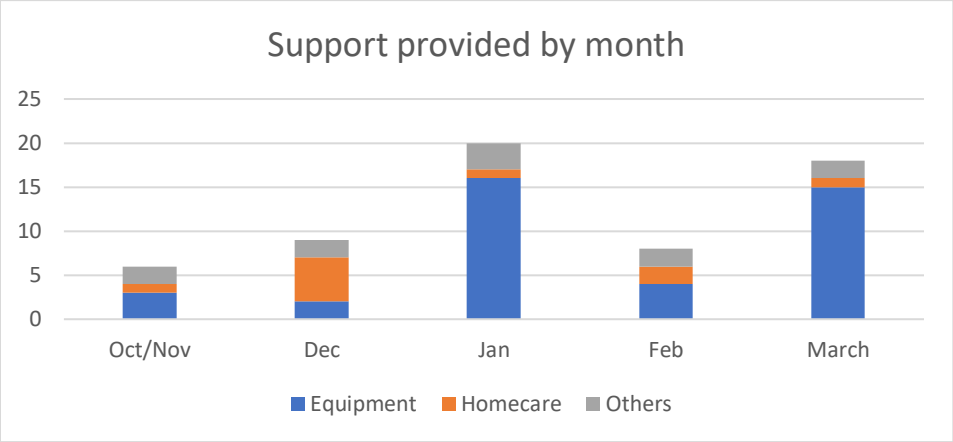
Flowchart: Request Process for Hospital NICE Fund

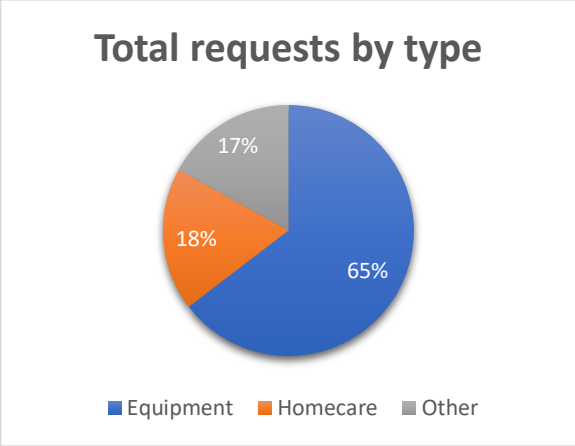


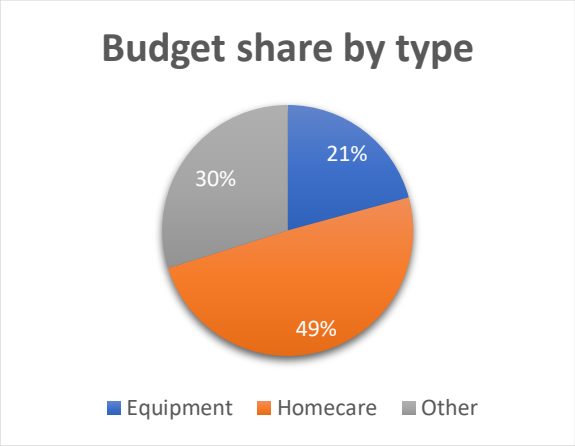
Outputs

65 REQUESTS PROCESSED

56 PATIENTS PROVIDED WITH SUPPORT







Types of request

- The majority of requests (65%) were for equipment (mainly walkers)
- Approximately half of the budget was spent on homecare (mainly PSW supports)

Utilization of Funds

- $50,719.57 worth of requests was processed and $45,626.12 was paid out
  - The difference is due to a change in length of service or patient need
  - Additionally, some patients declined the services (e.g., no longer needed the support or passed away)
- By March 31st, approximately 60% of the budget had been spent

FINDINGS

In the focus group, TNs were asked to share their perceptions of the program. Key themes are summarized below.

Impact on Patients	**Sample Quotes**
Shortened length of stay	"[Finding a wheelchair] would have been **another day or two in hospital for me to try** and arrange or get someone to go, a family member to get her wheelchair and bring it here. And within half an hour, the problem was solved and the patient was ready to go."
Reduced Readmission for Certain Patients with mobility issues	"[We have] repeat customers, as I say, or frequent fliers. We don't have stats or anything as TNs, but I can't see how it wouldn't [prevent readmission], because if we were sending somebody home without—with only LHIN supports, and without that top-up, especially falls-risk patients; like, they're back two days later – home – back two days later."
Reserving hospital equipment for in-patient use	"On Ortho, we've given patients, before we had the NICE Fund, crutches – like our own crutches, that Physio uses to get patients up, or walkers, and then we don't have the equipment for the patients when they're here. So, the NICE Fund definitely helps."
Improved quality of life for patients	"Have the private PSW sources to actually get involved for a short period of time before either LHIN comes in, or to supplement at the very beginning when the person goes home, to settle in, to make sure that the person is actually kept the surfaces, and the hands-on kind of things."
Patient satisfaction	"They won't take it for granted. They'll be taking it as an, 'Oh my gosh, that's a good thing' type of situation."
Extra support for patients with social admits	"Unless you're on ODSP or, you know, some other program, funding for equipment is very minimal. And, I mean, we get a lot of homeless patients that just don't have money and are all of a sudden needing equipment; so, there's just no option for them, or people who just don't have the funds. And if that's the one barrier, and we can pay for a $250 walker, then here we go."

Impact on Process	**Sample Quotes**
Easier and faster process to address barriers to discharge (shortened approval process)	"[In the absence of the fund], it takes longer to try and figure things out. And that's when I have given equipment from the hospital; like I've gotten approval from management to give, you know, crutches or a walker to somebody, that belongs to us."
Teamwork	"There's different ways that a patient gets flagged to us; but I think we all kind of work together in terms of what patients need to go home – and so, yeah, many times it's been like, PT will approach me and the person can go home, but we need to get them a walker."
Working closely with patients and families	"We work with the patient… [we ask] if we have this done and you have these resources, then is it OK for you to go home then? Or what else is the obstacle, or barrier, for you to go home?"
Budget constraint on mind	"You don't just go use the NICE Fund, because it is a limited amount of money."

Concerns and Suggestions from Transition Navigators

Concerns	**Sample Quotes**
What to do in the absence of the fund?	"What do we do in the summer when people are stuck and they need a walker?"
Managing patients' expectations	"I have a lady that we got three walkers for, because every time she came back, she didn't have the one she got before – and she just knew, in order to go home, we'll give it to you again."
Suggestions	**Sample Quotes**
Expand to rest of the year	"These people live this way all the time, and they're always going to need help."

Project Outcomes

Expected Outcome	*How Did They Do?*
Address barriers preventing timely transition back to the community	Yes
Support safe transitions home	Unable to evaluate.
Support patient flow	The number of requests increased in comparison to last year
Reduce length of stay for patients ready to be discharged	While Transition Navigators believed LOS was shortened, the evaluation team was not able to assess their perception
Utilize 90%+ of funds	By March 31st, 60% of the budget was spent

RECOMMENDATIONS

The Hospital NICE Fund is a well-run project whose impact could be amplified with some minor changes. We recommend the following for next year's surge initiative.

1. Establish guidelines for eligibility and approval process
    - Currently, there are no formal criteria for identifying which patients should access the fund. Instead, transition navigators use their judgment to identify eligible patients and what supports they need
    - While there is value in this approach, it can also lead to uneven application of the funds. For example, criteria for approval might be more stringent in some units or on certain days, depending on who is assessing the patient
    - More structure around eligibility criteria and the approval process would ensure the fund is equitably distributed among those who need it the most while achieving its goal of alleviating surge pressure
2. Link the Community, Hospital, and Primary Care NICE Funds
    - These initiatives are similar but currently are not connected in any way
    - The main goal of these initiatives should be keeping patients in the community
    - The hospital program would benefit from setting longer term goals such as keeping patients who are discharged in the community and reducing readmission rates
    - One possibility is to flag patients who use the Hospital NICE fund and put them in touch with the Community and Primary Care NICE Funds, so they can be pro-actively monitored
3. Consider extending funding to the rest of the year
    - TNs feel there is demand for this service year-round
    - While the amount of funds paid out increased significantly compared to last year, 46% of the fund still was not spent during the surge period
4. Manage patient expectations
    - Clearly explain to patients what the NICE Fund is and that the fund is available only during the certain months, to avoid confusion and difficulties in the future

NICE COMMUNITY FUND

LEAD ORGANIZATION: WOODGREEN COMMUNITY SERVICES

DATES: JANUARY 31, 2020 TO MARCH 3, 2020

PROJECT LEAD: JULIA CHAO, FRANCES MORTON-CHANG

TAKE-AWAYS

1. The types of support that accounted for the most spending were food security and transportation.
2. Shifting goals contributed to a lack of clarity among staff as to the program's purpose and scope.

INTERVENTION

- Provide practical one-time or time-limited supports to individuals being discharged from hospital acute care or emergency department to the community
- Provide practical one-time or time-limited supports to keep individuals from going to or returning to hospital
- Provide one-time financial support to access basic necessities or other supports where alternate resources are unavailable or exhausted, in order to stabilize a volatile or unsafe situation or ensure the individual's safety
- Funds are generally small amounts meant to address simple, low-cost needs
- Funds are meant to be quicker and easier to access compared to the organization's normal operating procedures, or to be an option when no other funding sources are available

Target Population

- Individuals being discharged from hospital acute care and/or emergency department back to the community
- Clients living in the community with immediate needs (e.g., food security, medical equipment, eviction protection)
- In either case, the population of focus was defined as frail individuals, isolated seniors, caregivers, individuals with mental-health or substance-use concerns, and clients with dual diagnosis.

GOALS

1. Facilitate transition for individuals being discharged from hospital back to the community
2. Reduce avoidable visits or returns to the hospital by community dwelling patients

COSTS

Budget: $28,160.80 of the $30,000 budget was spent

WHAT HAPPENED

Process

The process for accessing the Community NICE Fund was as follows:

1. Identify clients in need of support
2. Fill in request form documenting:
    - Category of need (necessities, safety equipment, time-limited services)
    - Date of request
    - Request made by
    - Request made for
    - Amount of request
    - Payable to
    - Brief description of nature of request (reason for request, client circumstances, need, etc.)
3. Once request is approved, obtain the supports needed by client
4. Submit receipts for reimbursement

The above tasks were done by front-line staff at WoodGreen (typically social workers), who accessed the fund on behalf of their regular WoodGreen clients.

Note: While the program did not restrict use of funds to only WoodGreen clients, in practice only WoodGreen clients were considered for support.

Evaluation Activities

Quantitative

- To understand how the funds were used, the evaluation team analysed expenditure data provided by WoodGreen

Qualitative

- To gain a further understanding of the project's operations and impact, the project lead was interviewed
- The evaluation team also held a focus group with three social workers (by videoconference) to ask their thoughts about the impact of the program, challenges they faced, and how the program can be improved

Outputs

37+ **REQUESTS PROCESSED**[‡]

30+ **PATIENTS PROVIDED WITH SUPPORT**

[‡] Based on data provided by WoodGreen, 37 requests were submitted to the Community NICE Fund, with 30 unique patients receiving support. In addition, $10,000 was spent on "Food security (Meals on Weels) [sic] and transportation support," which benefited an unspecified number of "transportation clients."

Requests, by Month

Month	Jan	Feb	March	Total
#of requests	1+	35	1	37+

Requests, by Type

Type	Mattress and other basic household items	Extreme cleaning / cleaning /	PSW respite	Transportation & Food	Others
#of requests	10	7	5	6+	9

Utilization Trends

- At least 37 requests were processed
- Three main type of service were provided:
    - Care services including transportation, food security, eviction prevention, extreme cleaning and decluttering, and PSW services
    - Health and well-being including fall prevention equipment and mattress
    - Necessities including basic household items and medications
- The majority of the money was spent on care services.
- Out of nearly $24,000 spent on care services, more than $10,000 was spent on food security and transportation
- Time between requests to approval was reported to vary between 2 to 3 days to several weeks depending on the nature of the request

FINDINGS

What did we hear from staff?

Key themes from the focus group with social workers are summarized below.

Challenges	**Quotes from social workers**
Social workers were not clear about the purpose of the intervention as it relates to overall purpose of the surge initiative.	"It was [for] extending existing services that were about to be cut, and providing new support." "Well from what I understand it's to help fund things that otherwise would not necessarily be able to funded for individuals who are unable to afford, um, 'luxuries' like pharmacy bills." "My understanding was it was for immediate, or emergency, costs or reimbursements."
Social workers were unclear about the maximum amount or type of services covered by the fund.	"Every time I asked for something, I was like, 'eek, please' – 'cause I had no idea of the concept of how much there was, and if I was asking for too much."
Social workers were not clear about the eligibility criteria	"[It involved] identifying clients, and then doing kind of like a brief assessment without disclosing, 'oh, there's this pile of money'. Because I didn't want to share and then, them not being maybe eligible."
Clients rejected the services because it was short term support.	"They're like, 'what's the point of doing this if I'm only going to get it for a short period of time, what am I going to do after?' "
Strengths	**Quotes from social workers**
Extra support for clients	"The strength is that it provided things to my client that never would have happened."
Simple process	"The part I liked about it the most was I didn't need to submit notice of assessment, proof of income, proof of their other expenses. … It was kind of like, just following my judgement."

Implementation Issues

There was considerable drift from what was initially proposed to what happened in practice.

- For example, the goals in the initial proposal were to "Provide improved access to care, health promotion, address social determinants of health to Improve [sic] the health and well-being of year one priority populations"
- Whereas the plan presented by project leads described the intervention as providing "practical one-time or time-limited supports" to patients being discharged from hospital or to patients in the community
- In practice, it appears what happened is the funds were used by WoodGreen staff to extend existing services and providing new supports for WoodGreen clients.

While some changes are expected as a project moves from idea to implementation, the substantial gap between initial proposal to what happened in practice contributed to the following:

- Lack of clarity among WoodGreen staff about purpose and parameters of the Fund
- Lack of metrics to assess the effectiveness of the program

Project Outcomes

It is possible that the supports provided through the Community NICE Fund helped achieve the program's stated goals. However, based on the data provided, it is impossible to determine if this actually happened.

Expected Outcome	*How did they do?*
Facilitate transition individuals from hospital back to community	Unable to evaluate
Reduce avoidable visits or returns to hospital	Unable to evaluate

RECOMMENDATIONS

1. We suggest more time to be spent (before the start date) on designing the intervention to improve the potential impact. This will provide sufficient time to put necessary processes in place and to effectively communicate with staff. Partnerships also can be formed to increase the impact and outreach.
2. We suggest more time to be spent in the design phase to plan in detail what a successful program looks like; this will allow for identifying outcomes that are not only linked to the overall goals of the program but also measurable given data availability. It would also provide the program with ample time to have processes in place for tracking what's necessary for evaluation purposes.
3. We suggest the following ideas be considered to improve the program:
   3.1. A partnership between Community NICE Fund (WoodGreen) and the Hospital NICE Fund (MGH) as a way to identify patients/clients in need of more support in the community. The purpose of the Hospital NICE Fund was to discharge patients early to alleviate surge pressure; these patients can be flagged to WoodGreen to receive extra support in the community. This ensures that patients discharged from hospital will remain in the community and could decrease readmission or avoidable ED visits.
   3.2. WoodGreen should:
      - Identify common services or supports that could alleviate surge pressure
      - Identify high-need clients and provide them with additional support to prevent avoidable admission to MGH during surge months.

PREVNAR13 SURGE PROJECT

LEAD ORGANIZATION: EAST TORONTO FAMILY PRACTICE NETWORK (EAST-FPN)
PROJECT LEAD: DR. MICHAEL CHU
PARTNER ORGANIZATIONS: MGH, PFIZER CANADA
DATES: JANUARY 6, 2020 TO MARCH 28, 2020

TAKE-AWAYS

1. Lifetime vaccination against pneumococcal disease was made available to at-risk patients in financial need
2. Leadership engagement was critical to uptake and success in engaging primary care physicians
3. Dedicated project management played a very important role in smooth implementation of the program

INTERVENTION

- Prevnar13 vaccine provided to patients who do not have insurance or means to pay the $125 cost[4]
- Targeted to a higher-risk population: patients over 65 with risk factors for pneumococcal diseases
- Available to patients registered with EasT-FPN, a newly developed network that aims to include 200 family physicians in east Toronto
    - The project also intended to motivate primary care practitioners' engagement with East-FPN

GOALS

1. To administer 500+ doses of Prevnar13
2. To reduce ER visits and admission due to pneumococcal disease
3. Increase the number of high-risk, low income patients who can access the vaccine Prevnar13
4. To engage PCP in activities related to the Network of the EasT-FPN.

COSTS

Budget: $50,000

Note: All funding was used for vaccine purchase. Administrative and project management costs were covered using existing staff at EasT-FPN or MGH.

[4] Prevnar13 has been recognized by National Advisory Committee on Immunization (NACI) to be effective against pneumococcal pneumonia and *p*neumococcal invasive disease. NACI cites the high price of Prevnar13 as a reason that it is not publicly funded on a universal basis. (See: https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci.html.)

WHAT HAPPENED

Process

1. EasT-FPN physicians were introduced to the Prevnar13 project via board meetings, word of mouth from the project lead, invitation emails or the EasT-FPN website
2. East-FPN configured its website to include an electronic platform for placing vaccine orders
3. Physicians identified eligible patients and placed orders through East-FPN website
4. The Pervnar13 project manager worked with MGH to place the order and complete a financial transaction with Pfizer Canada
5. Pfizer Canada delivered the vaccine to the ordering physician

Evaluation Activities

Quantitative

- To gain insights into the project's reach and impact, administrative data including vaccines administered and information on type of practice and location were analysed
- A survey co-developed with the evaluation team was sent to all ordering physicians to assess their perceptions of the project's importance and experience of the process

Qualitative

- To understand of the project's operations and impact, interviews were conducted with the project lead and manager
- Answers to open-ended questions on the provider survey were analysed to gain further insight into provider experience

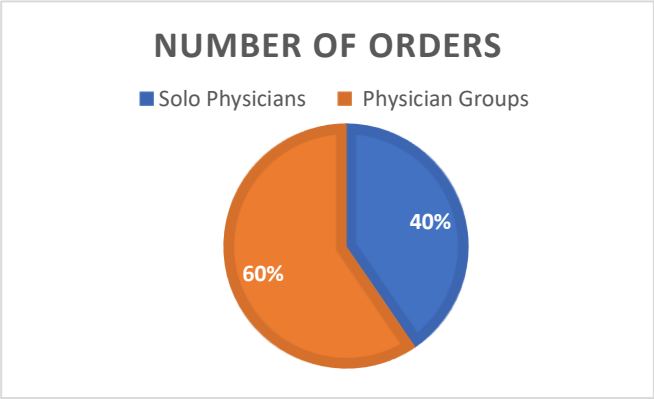
Outputs

356 DOSES OF PREVNAR13 WERE ADMINISTERED

60 PROVIDERS PLACED ORDERS

Uptake by Primary Care Practices

- Out of the 200 physicians that the EasT-FPN is trying to actively engage in the network, 60 providers ordered the vaccine
    - 24 solo physicians placed orders
    - 7 group practices placed orders (from multiple providers)
- Of the 356 orders:
    - 144 were from solo physicians
    - 212 were from group practices



Location of Practices that Participated

The physicians and clinics that ordered vaccines covered 8 different postal districts in East Toronto neighbourhoods.

FINDINGS

The findings are organized according to the project's primary goals, as well as providers' experience of the project. The provider experience survey measured the following domains, which collectively assess the experience of ordering the vaccine and engaging the network, as well as the importance and impact of the vaccine administration:

- Perceived importance of the project
- How easy or not was the vaccine ordering process
- Long-term impact of the project
- Perception of the project as a motive to join a primary care network

The survey response rate was 29%, which matches the known low response rates for primary care providers.

Administer 500+ doses of Prevnar13

- 356 doses of Prevnar13 were administered (144 via solo physicians and 212 via group practices)
- The remaining 144 doses had to be cancelled as COVID-19 hit and primary care practices were closed
- There was a cap of six doses per physician

Reduce ED visits and admission due to pneumococcal disease

- Assessing this goal directly was not possible as it is a long-term goal that requires linking to hospital administrative data.
- However, there is an item in the provider experience survey that asks the providers: "Do you think having given Prevnar13 to your patient will effectively reduce your patient's admission to the hospital?" 77.8% of the survey respondents answered 'Yes' for this question and the remainder answered 'I don't know'

Increase the number of high-risk, low income patients who can access Prevnar13

- Although we don't have a baseline number to compare the number of patients who accessed Prevnar13 via this project to others. We do know that this is a lifetime vaccine, so any patient who got the vaccine is an increase to the number of vaccinated patients. The inclusion criteria set by the project leads to direct the ordering physicians to only include patients who are high risk and cannot have access to the vaccine otherwise due to financial restraints, further suggesting that this goal was achieved.

Engage PCP in activities related to the Network of the EasT-FPN

- Out of the 200 physicians that the EasT-FPN is trying to actively engage in the network, approximately 60 providers ordered the vaccine (24 solo physicians and 7 group practices)
- The project leads perceive this number as "a great unexpected success", given that the network is relatively new, the short duration of the project, and the difficulty (well documented in research literature) of engaging primary care providers in new initiatives
- When provider-survey respondents were asked: "would providing such services within primary care networks motivate you to join networks such as EasT-FPN":
  - 77.8% strongly agreed
  - 11.1% agreed
  - 11.1% neither agreed nor disagreed

Provider survey respondents' perceptions of importance and need

- "How do you rate the importance of pneumococcal disease vaccination"
  - 66.7% selected extremely important
  - 11.1% selected very important
  - 22.2% selected somewhat important
- "How often do your patients refuse the vaccine because they are unable to afford it"
  - 55.6% selected usually
  - 44.4% selected sometimes

Provider survey respondents' experience with the process of vaccine ordering

- "On a scale of 1 to 10, rate the process for ordering the Prevnar13 Vaccine"
  - 66.7% selected 10
  - 11.1% selected 9
  - 11.1% selected 8
  - 11.1% selected 5
- "Were the supplies of vaccine sufficient to service your patients who needed it"
  - 77.8% selected yes
  - 22.2% selected no
- "Have you become more knowledgeable about pneumococcal vaccine as a result of this initiative"
  - 77.8% selected yes
  - 22.2% selected no

In the survey, 55% of the respondents stated that they learned about the Prevnar13 project from Dr. Chu, the lead of the project, either directly through a phone call or word of mouth, or upon attending a board meeting at the EasT-FPN. This reflects how engaged leadership can help motivate primary care providers to try new initiatives in primary care settings.

Project Outcomes

Expected Outcome	*How Did They Do?*
To administer 500+ doses of Prevnar13	Successful. 500 doses were ordered by physicians/clinics. However, only 356 doses were actually administered. Administration of the remaining 144 doses had to be cancelled due to COVID-19.
To reduce ER visits and admission due to pneumococcal disease	Unable to assess
Increase the number of high-risk, low income patients who can access the vaccine Prevnar13	Successful. Although we do not have a baseline number to compare the number of patients who accessed Prevnar13 via this project to others, we do know that this is a lifetime vaccine: any administration of the vaccine is an increase to the number of permanently vaccinated patients.
To engage PCP in activities related to the Network of the EasT-FPN	Successful. The project was able to engage 60 physicians from a newly formed network of 200 physicians.
The perceived importance of the project	Successful. More than two-thirds of respondents to the provider survey perceived the project as important.
Provider experience in terms of how easy or not the process of vaccine ordering was	Successful. More that 85% of provider survey respondents reported that the ordering process was easy.

RECOMMENDATIONS

Should this program run again?

1. Yes, this was a successful program however funding may not be necessary if those with financial need can access the immunization through available government assistance programs

MENTAL HEALTH SURGE PROJECT

LEAD ORGANIZATION: SEAMLESS CARE OPTIMIZING PATIENT EXPERIENCE (SCOPE)/EAST TORONTO HEALTH PARTNERS (ETHP)

PROJECT LEAD: DR. RUTH HUSSMAN

PARTNER ORGANIZATIONS: MGH, ALBANY CLINIC, HEALTH ACCESS THORNCLIFFE PARK (HATP)

DATES: DECEMBER 18, 2019 TO MARCH 28, 2020

TAKE-AWAYS

1. Demand for urgent mental health services is high
2. 90% of patients said this service was important to them
3. Consider extending the initiative to be a year-round program

INTERVENTION

- Rapid access to urgent psychotherapy, counselling, and connection to longer-term supports
- Available to patients of SCOPE family practices through referral by primary care providers
- Targeted to patients in urgent need of psychotherapy and related services who do not have private insurance or the means to pay out-of-pocket
- Staffed by 6 social workers who worked part-time at 3 locations
    - 4 at Health Access Thorncliffe Park
    - 3 at the Albany Medical Clinic
    - 1 at Michael Garron Hospital
      (2 worked at multiple locations)
- Available after hours and on weekends
- SCOPE/ETPH responsible for design and oversight of the project

GOALS

1. Provide access to urgent psychotherapy services – i.e., short-term (1-4 sessions) and community-based psychotherapy and counselling services – for those who need it among patients of SCOPE primary care physicians
2. Provide those services on weekends and after hours
3. Connecting clients who need more comprehensive services to community resources for longer-term needs
4. To enhance engagement of physicians within SCOPE with new services offered through the network
5. Enhanced patient experience
6. Enhanced primary care provider experience

COSTS

Budget: $60,000

WHAT HAPPENED

Process

1. SCOPE family physician/practice identified potential patients and initiated a referral
2. A designated social worker and nurse navigator at MGH received referrals and called patients to schedule appointments
3. Patients accessed 1-4 visits with a social worker
4. If patients were assessed as requiring further support, the social worker arranged connections with appropriate community resources
5. The social worker prepared a report and sent it back to the referring physician to ensure continuity of care

Evaluation Activities

Quantitative

- Analysis of administrative data collected by the project manager, including information on referring physicians, number of referrals, number of sessions, and demographics of patients
- Analysis of the results of provider and patient experience surveys

Qualitative

- To understand of the project's operations and impact, the project lead was interviewed
- To gain further insight into provider experience, answers to open-ended questions on the patient and provider surveys were also analysed

Outputs

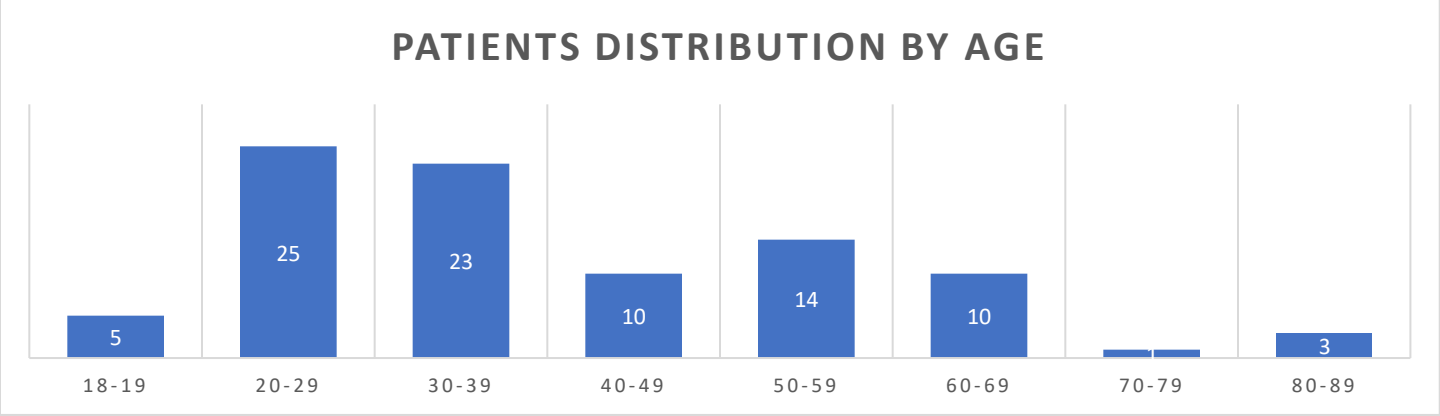
299 SHORT-TERM PSYCHOTHERAPY SESSIONS

113 PATIENTS ACCESSED THE SERVICE

59 PHYSICIANS USED THE PROGRAM

Demographics

- Most of the patients who used the program were female
  - 76 (67.2%) female
  - 37 (32.3%) male
- The youngest patient was 18 years old and the oldest was 89
  - Nearly half of the patients were between 20 and 40 years old (the age distribution is shown below
  - Age distribution is shown in the figure below



FINDINGS

Findings are grouped by the project's goals and based on the evaluation activities described above, including the surveys of patients and providers.

- The provider survey was distributed to the 59 physicians who made referrals; 19 participated, for a response rate of 32%
- Due to COVID-19, patient experience surveys could only be distributed to 47 of the 113 individuals who accessed the program. Of the 47 surveys distributed, 32 were completed, for a response rate of 68.1%

Provide access to urgent psychotherapy services for those who need it among clients who are patients of a SCOPE primary care physician

Through the Mental Health SCOPE project, 113 patients were able to access 299 free short-term psychotherapy sessions.

28% of patients used one session, 44% used two sessions, 17% used 3 sessions and 11% used 4 sessions, which is the maximum number allowed per patient. 13 out of 32 of patients (40%) who participated in the patient experience survey reported that this was their first time accessing mental health supports, which reflects the need of such services. The provider experience survey included the question: How important was it for you to be able to able to connect your patient to Mental Health support through the SCOPE network?

- 84% of respondents answered very important
- 16% answered important

Provide those services on weekends and after hours

Across the three sites, around 83% of visits occurred on evenings and weekends. Additionally, the importance of offering evening and weekend options was expressed by 26 out of 32 (81%) patient survey participants as very important or important.

Connecting clients who need more comprehensive services to community resources for longer-term needs

81 patients (71%) were connected to community resources for longer-term psychotherapy and counselling. Examples of these resources include:

- Seniors' groups through Woodgreen Seniors Services
- Connection to Ontario Age Security regarding finances
- Trauma counselling at the Queen West Community Health Centre
- Psychotherapy counselling via East End Community Health Centre
- Family Services Toronto – priority housing
- Application assistance for Supportive Housing in the Province (SHIP) – Mental Health Supportive Housing

Enhance engagement of physicians within SCOPE with new services offered through the network

The primary care providers registered with SCOPE are 98 physicians. Of them, 59 (60.2%) physicians referred patients to the program. About 12% of the physicians made between four and six referrals and the majority made 1-2 referrals (there was no cap on the number of patients referred to the program by each physician). In the provider experience survey, when participants were asked: "Would providing such services within primary care networks motivate you to join these networks?"

- 79% strongly agreed
- 21% agreed

Enhanced patient experience

When patients were asked: how important was it for you to get mental health support through your family doctor?

- 25 survey respondents (78%) said it was very important
- 5 (16%) said it was important

The reason for such importance was expressed by the patients as:

- "My family doctor is my go-to for all my health needs, he is the one I would go to for all health-related services"
- "If I didn't get it through Dr. [name redacted], I couldn't have any services right now"
- "Impressive that GP got on it right away – within 1-week, quick access."
- "For the awful place I was in—I needed help and GP helped me connect to something and speeded the process"

The open text comments were mainly about requests to continue the program for the entire year.

Enhanced primary care provider experience

In order to assess the process of connecting a patient to the program, provider-survey respondents were asked: How easy was it for you to connect your patient to the Mental Health Support Program?

- 78.95% selected very easy
- 21.05% selected easy

Project Outcomes

Expected Outcome	*How Did They Do?*
Provide access to urgent psychotherapy services (i.e., short-term (1-4 sessions) and community-based psychotherapy and counselling services) for those who need it among clients who are looked after by a SCOPE primary care physician	Successful. 113 patients were able to access 299 free short-term psychotherapy sessions.
Provide those services on weekends and after hours	Successful. 81% of the patients reported that it was very important or important to them to receive services on weekend and after hours.
Connecting clients who need more comprehensive services to community resources for longer-term needs	Successful. 71% of the patients were connected to community resources for longer-term psychotherapy and counselling.
To enhance engagement of physicians within SCOPE with new services offered through the network	Successful. 60% of SCOPE physicians referred patients to the project.
Enhanced patient experience	Successful. More than 90% of the patients perceived the project as important to them.
Enhanced primary care provider experience	Successful. Physicians perceived the project as important to their patients and easy to refer to, and they requested to have it in place for the entire year.

RECOMMENDATIONS

Consider expanding the program to run all year. There is a high need within the community and significant engagement with the program team and referring physicians to implement process improvements (i.e., introducing electronic platform for scheduling and possible virtual sessions due to COVID-19).

OAKRIDGE HEALTH AND HARM REDUCTION HUB

PARTNER ORGANIZATIONS: AGINCOURT COMMUNITY SERVICES ASSOCIATION (ACSA), COTA, COMPREHENSIVE TREATMENT CLINIC (CTC), INTER-PROFESSIONAL TEAM (IPT) – UNITY HEALTH, MICHAEL GARRON HOSPITAL (MGH), SOUTH RIVERDALE COMMUNITY HEALTH CENTRE (SRCHC), ST. MICHAEL'S HOMES (SMH), WARDEN WOODS COMMUNITY CENTRE (WWCC)

LEADS: JASON ALTENBERG, PAUL BRUCE (EXECUTIVES), LEAH DUNBAR (PROJECT MANAGER)

DATES: FEBRUARY 4, 2019 TO APRIL 17, 2020[5] (SURGE PILOT END DATE – OPERATIONS ONGOING)

TAKE-AWAYS

1. 8 service-provider organizations collaborated successfully to establish a multi-service 'Hub' to address problematic substance use in a community with high rates of overdose and other crisis situations
2. Steady uptake in service utilization prior to the COVID-19 pandemic; some services remained operational and have continued beyond the Surge-funded pilot period by the partners using alternative funding
3. Having a dedicated project manager was crucial to addressing operational issues and ensuring continuity of care

INTERVENTION

- Oakridge district in west Scarborough selected for a targeted pilot intervention, based on emergency services data indicating a high number of crisis situations related to problematic substance use
- Surge investment and in-kind contributions from 8 partner agencies established a multi-service Hub offering a comprehensive range of supports for people who use substances
- Services available on a walk-in basis: harm reduction at all times, one-on-one and group-based supports at scheduled times
- Operations were impacted by the COVID-19 pandemic but continued on a limited basis after service adjustments were made on March 13 (see below)

GOALS

1. Build an effective partnership for identifying and responding to local needs pertaining to problematic substance use in the Oakridge neighbourhood
2. Establish a site where multiple agencies collaborate in supporting clients
3. Promote utilization through low-barrier services and outreach
4. Reduce use of acute-care services by people with substance-use issues through access to team-based services
5. Reduce the need for emergency services related to overdoses

COSTS

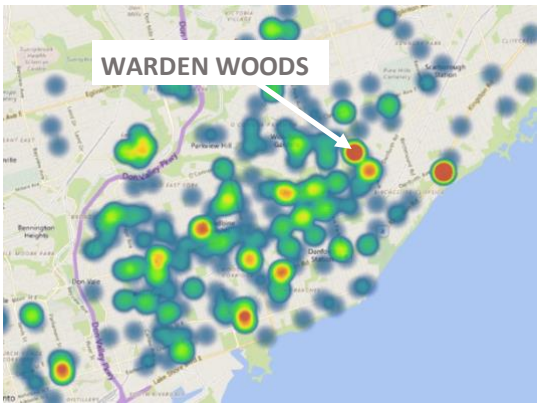
Budget: $117,000 (~$50,000-$65,000 spent)
Operating expenses: $24,894
Site readiness: <$40,000

[5] Given that Sure funding was used for site readiness and other activities to initiate the pilot phase, the evaluation period was extended to coincide with an extension of the pilot phase in order to capture the impact of this investment. Expenditure of Surge funds ended on March 31; core operational funding has been provided by Cota and SRCHC in the period since. Also, while services began on February 4, the evaluation covers planning and intervention-design activities that occurred within the Surge-funded period prior to this date.

WHAT HAPPENED

Process

- The Substance Use and Health Working Group of the East Toronto Health Partners (ETHP), an Ontario Health Team, convened a partnership to build local capacity to address the impact of problematic substance use
- Partners selected the Warden Woods community, in the Oakridge neighbourhood of west Scarborough, for a multi-service pilot project
    - Warden Woods has a high concentration of overdoses and other crisis situations related to substance use, as do several other communities nearby
    - Warden Woods mostly consists of high-rises and townhouses operated by Toronto Community Housing; it is more geographically isolated than other lower-income areas, and a considerable distance from specialized service providers
- ETPH identified potential partner organizations and convened planning sessions involving their leaders as well as community members



'Drug Abuse and Related Visits', MGH ED

- Space at 76 Firvalley Court was made available as an in-kind contribution from WWCC
    - The space has its own entrance and is otherwise separate from the community centre, which aligns with the partners' aim of creating a dedicated space to meet the needs of people who use substances
    - The space includes a large room with the harm-reduction service table, information boards, and an area for clients to use a computer and interact informally with workers; separate rooms for scheduled group activities and one-on-one client encounters; and an office for staff
- Surge investment was used for site readiness, security, cleaning, and non-clinical supplies
    - Funding for renovations was provided to WWCC
    - MGH processed financial transactions for operations during the Surge-funded period
    - Full-time project manager was seconded from MGH as a separate (non-Surge-funded) in-kind contribution
- Client services were provided as in-kind contributions by partner agencies (see tables below)
- An extensive outreach strategy was developed and implemented by the partners
    - Staff from partner organizations that do ongoing harm-reduction work in the neighbourhood promoted the Hub through outreach to their regular clients; they were joined by staff from organizations new to the neighbourhood, who set up information tables in the lobbies of nearby public-housing buildings
    - Posters were put on lamp posts in the neighbourhood, and for several kilometres along busy avenues nearby
    - Three community events hosted or co-hosted by the Hub were used as an opportunity to promote its services

Services Offered

Delivery of all services was affected by the COVID-19 pandemic. Harm-reduction was identified as an essential service and continued with reduced hours; other programs continued to the extent that circumstances permitted. Adjustments made in response to the pandemic were implemented on March 13 and are noted in the tables below.

Harm-Reduction

Service ***Providers***	**Description**	**Post-March 13***
Harm Reduction *ACSA, SRCHC, WWCC*	Supplies and information to help people use drugs more safely, including overdose prevention (naloxone)	SRCHC continued with reduced hours

Other One-on-One Services

Service ***Providers***	**Description**	**Post-March 13**
Addiction Medicine *CTC*	Medication and non-medication treatment options through telemedicine sessions with a physician	Continued
Case Management *Cota*	Information, referral, encouragement, and emotional support to help clients develop and meet goals	Avail. by phone (no uptake)
Counselling *MGH, SMH*	Coping strategies, mental-health education, and referral	Modified*
Crisis Intervention *WWCC*	Crisis counselling for people on low-incomes who have mental-health issues	Avail. by phone (no uptake)
Housing Assistance *WWCC*	Support for housing issues, including eviction	Avail. by phone (no uptake)
Nurse *IPT*	Support for stress, chronic illness, navigating health & social services	Continued

**The counselling service provided by MGH (Tuesday 9 a.m. to 5 p.m., Wednesday 9 a.m-11 a.m.) was suspended. Counselling (with physical-distancing measures in effect) is now available for 3 hours per week when an SMH staff member is on site.*

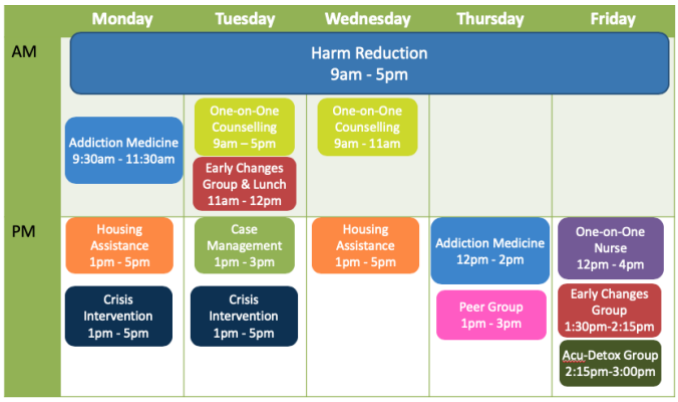
Group Services (Suspended March 13, 2020)

Service ***Providers***	**Description**
Acu-Detox *Cota*	Acupuncture treatment and meditation to help with anxiety, depression, and stress in the context of substance use
Early Changes* *Cota, SMH*	Encourages positive changes with education and reflection, through group discussions and activities; followed by lunch and informal one-on-one sessions with the facilitator
Peer Group *Cota*	Group discussion and art activities facilitated by people with lived experience of mental health and substance-use issues

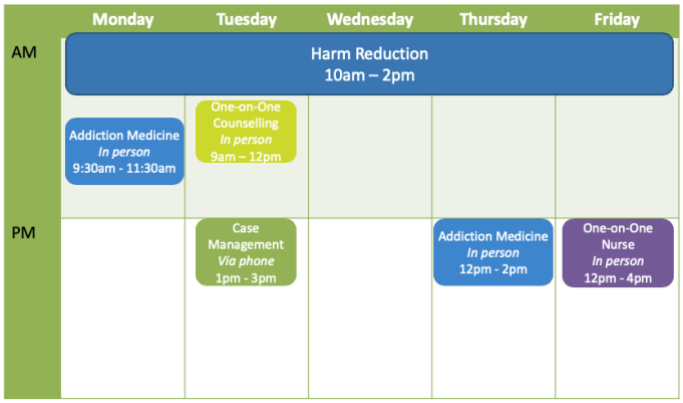
**SMH and Cota offered separate Early Changes groups at different times. The organizations collaborated to ensure consistency in terminology, approaches to supporting clients, and strategies for outreach.*

Service Availability

February 3-March 13



Post-March 13



Evaluation Activities

Quantitative

- Data on service utilization (i.e., client encounters, supplies distributed) was tracked by partners, compiled by the project manager, and analysed by the evaluation team[6]
- A survey was implemented by the Hub, asking clients about satisfaction, how they heard about the clinic, and their neighbourhood of origin
- A confidential, evidence-based survey for evaluating partnerships (the Wilder Collaborative Factors Inventory) was distributed to leaders of partner organizations and the Hub initiative overall; a 100% response rate was achieved among the 10 potential respondents

Qualitative[7]

- An evaluation team member met with the project manager to discuss Hub operations and evaluation activities prior to the start of operations; during the pilot period they had weekly phone updates to discuss Hub operations and evaluation-relation issues
- The evaluation team member observed planning meetings and co-led a sub-group of partners and community members that was established to support the evaluation
- Observations were conducted through participation in staff training and 2 community events, and unobtrusively observing public areas of the Hub following visits for events and meetings
- Partner-organization leads (8 total) and the project manager were interviewed toward the start of the pilot period
- Exit interviews were conducted with the 2 executive leads and project manager; feedback from other partners was sought at partner meetings toward the end of the pilot period
- Interviews were conducted with 6 frontline staff from 3 different agencies (1 participant was identified as a key informant and 5 were approached informally while the evaluation team member was on-site)
- A focus group was conducted with staff from one 4 service-provider agency (via videoconference)

[6] To offer anonymity when possible, and for other logistical reasons, the partners decided not to track unique individuals visiting the Hub or implement a centralized record-keeping system.

[7] A community forum and client focus groups scheduled for mid-March had to be cancelled on short notice; further planned follow-up with clients and community members was not feasible due to the COVID-19 pandemic.

Outputs

311 HARM-REDUCTION CLIENT ENCOUNTERS

60 ENCOUNTERS FOR OTHER ONE-ON-ONE SERVICES

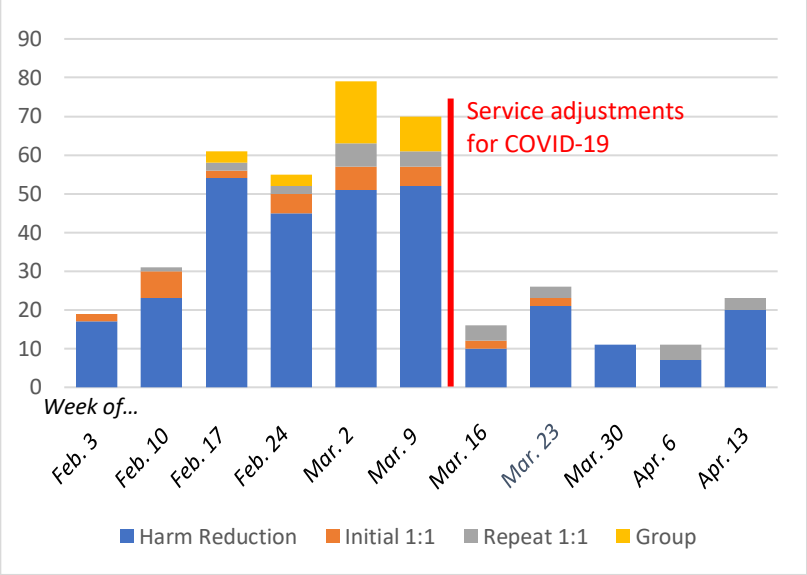
31 GROUP ATTENDEES

Initial and Repeat Encounters

Of the 60 encounters for one-on-one services such as counselling, addictions medicine, and crisis support:

- 31 were initial encounters (clients using the service for the first time)
- 29 were repeat encounters (clients returning for the same service)
- While clients were not tracked individually, repeat-encounter data for the addiction medicine service suggests that several clients began treatment and have continued on a regular basis

Service Utilization



Harm-Reduction Supply Distribution

The high ratio of items distributed to clients served, and feedback from harm-reduction workers, suggests these items reached a greater number of people than those who visited the Hub (see 'Secondary Distribution' below in Findings).

90	Naloxone (overdose-prevention) kits
392	Safer-use kits (prepared by harm-reduction workers)
3,228	Loose items (e.g., needles, safer-sex supplies)
3,710	**Total items distributed**

FINDINGS

Utilization

- As anticipated by the partners, utilization was low in the first several weeks; in subsequent weeks leading up to the COVID-19 situation:
    - Utilization of the harm-reduction service increased rapidly
    - Other services saw a more gradual, yet steady, increase in uptake
- Partner-organizations collaborated on strategies to increase uptake of services that had the lowest uptake in the early weeks, by adjusting outreach activities and schedules based on feedback from partner-organizations whose services saw higher uptake
    - The services that were adjusted had modest increases in utilization in subsequent weeks
- Even when all groups and one-on-one services were operating, the significant majority of service encounters were for harm-reduction supplies and information
- Supply distribution, and overall visitation, was much higher on 2 days when the Hub hosted or co-hosted community events

Client Engagement

- In interviews and informal focus groups, the project manager and staff from frontline agencies reported that outreach in nearby public-housing buildings was the most effective strategy for attracting clients
    - Partners also reported that it is most effective to promote scheduled services and special events intensively on the same day they are offered (rather than in advance) – service-utilization and event-attendance data support this interpretation
- Staff and leads perceived that once initial outreach was initiated, word-of-mouth and informal peer outreach would broaden the client base
    - Harm-reduction workers perceived this had begun to happen by early March, when the had several busy days on which staff mostly saw new clients. (While the number of unique individuals who used the harm-reduction service was not tracked in order to offer anonymity, overall utilization was highest in these weeks.)
- Hub staff and the project manager suggested that the harm-reduction service, and availability of a 'safe space', might have encouraged some clients to subsequently access one-on-one services or attend group sessions
    - Other services saw more gradual uptake than the harm-reduction service
    - Direct outreach and adjustments to the schedule were perceived as also contributing to the gradual uptake
    - Partners expressed a strong perception that peer-to-peer promotion of one-on-one services and group attendance was gaining momentum prior to the disruption caused by COVID-19; attendance data indicates increases in service utilization during this period

Harm Reduction: Secondary Supply

- Distribution data and feedback from frontline workers suggest that 'secondary supply' led to harm-reduction supplies reaching a larger number of people than those who visited the Hub (i.e., individuals would pick up a large number of supplies and serve as informal distribution points for peers)
- Best-practice guidelines[8] suggest secondary supply is an effective way to reach people who are reluctant to access harm-reduction services directly, and encourage eventual engagement through peer connections
- Secondary supply is therefore perceived by Hub partners as a positive community-health outcome, as well as a potential means of encouraging new clients to access the Hub

[8] *See: https://www.catie.ca/en/programming/best-practices-harm-reduction*

Multi-Agency Partnership

- The partner survey results accord with observations and interview data suggesting that leaders perceived that the multi-agency partnership was successful in identifying and responding to local needs
    - Two open-ended comments on the partner survey suggested that more consultation with community members, especially potential clients, would have been beneficial; this is consistent with findings from interviews with frontline staff and some project leads.
- Organization leads expressed a strong willingness to make in-kind contributions and re-allocate resources to support the pilot project – but also noted that direct funding for service provision would be needed to sustain these contributions
- The positive feedback from organization leaders largely accords with observations of meetings as well as interviews with the project manager and frontline staff: there was a consistent focus on local socio-demographic context and location-specific factors in discussing overall strategy as well as details around implementation
- Challenges related to communication and collaboration were identified in interviews with frontline staff about day-to-day operations, and reflected in some answers to open-ended questions on the partner survey
    - Some staff expressed that opportunities for collaborative client care may have been missed due to lack of familiarization with other organizations' offerings and lack of mechanisms to follow up with clients who express interest in services offered at specific times
    - While decision-making processes ranked highly on the survey and were described positively in interviews with leads, some frontline staff and partner-survey respondents perceived that decisions weren't always made collectively
- Observations and feedback indicate that the project manager role was crucial to addressing challenges pro-actively, by serving as a point of contact for staff from various agencies and a liaison with partner leads

> "It's also a test-case scenario for Ontario Health Teams, to have partners come together in an innovative way – which might not have worked so cohesively in the past. The process for developing the concept, and engaging partners around shared and common goals, was very positive."
> – Partner Executive

Client Feedback

Although the response rate to the client survey could not be estimated and only 20 were completed, the responses provide insights into how the Hub was perceived by some clients. Staff noted that clients who spent more time at the Hub were more likely to complete the survey.

Most respondents indicated they might not have accessed services if the Hub weren't available

- Of 18 clients who answered the question, "If I did not come to the Hub, I would have gone to (check all that apply)":
    - 66.7% (12) indicated 'nowhere'
    - 25% (4) indicated 'hospital'
    - 25% (4) indicated 'home'
    - 16.7% (3) indicated 'family doctor'
    - 16.7% (3) indicated 'walk-in clinic'

A quarter of respondents reported they might have gone to the hospital. And, notably, 45% indicated 'nowhere' as their *only* response, suggesting the Hub engaged with people who would not ordinarily seek support.

Most respondents indicated they learned about the Hub through outreach by staff or peers

- Of the 16 respondents who answered a survey question about how they heard about the Hub:
  - 25% indicated direct outreach
  - 25% indicated peers
  - 19% indicated other agencies
  - 19% indicated noticing the physical presence of the Hub
  - 13% indicated posters and other advertising

Satisfaction

While the sample may not be representative, respondents indicated an average rate of 95% satisfaction across 6 questions pertaining to their experience of visiting the Hub.

Project Outcomes

Expected outcome	*How Did They Do?*
Build an effective partnership for identifying and responding to local needs pertaining to problematic substance use in the Oakridge neighbourhood	• Successfully used data to target the intervention and engage 8 partner organizations in planning and delivery. • Organizations familiar with the local community and peer workers with lived experience were engaged in planning and service delivery, and potential clients participated in planning sessions. • The partnership was ranked highly in a survey of organizational leads and described positively in interviews with frontline staff.
Establish a site where multiple agencies collaborate in supporting clients	• Successfully established the Hub, open Monday to Friday with an array of services. • Harm-reduction supplies and information about other services were available from frontline staff whenever the Hub was open.
	• Staff collaborated informally to use their specialized skills to support clients, however lack of formal follow-up mechanisms and referral pathways posed a barrier to connecting some clients with optimal services. Staff perceived that more time and resources for familiarization and outreach would have been beneficial.
Promote utilization through low-barrier services and outreach	• Successful efforts to promote the Hub and address potential barriers to access led to significant uptake within a period of weeks. • Community outreach strategies promoted the Hub as a safe space for clients, and the service model ensured services could be accessed anonymously whenever possible.
Reduce use of acute-care services by people with substance-use issues through access to team-based services	Unable to evaluate.*
Reduce need for emergency services related to overdoses	Unable to evaluate.*

**Tentative plans to use data on EMS calls and ED utilization from area targeted for a comparison using the same period last year as a baseline were not feasible due to unforeseeable circumstances. The disruption of services due to COVID-19 less than 6 weeks after the Hub opened, as well as the impact of COVID-19 on hospital utilization and the impact of social distancing on overdose-prevention strategies, make it impossible to reliably discern the impact of the Hub on these indicators during the pilot period.*

RECOMMENDATIONS

1. Ongoing project management is essential to ensure partners can collaborate successfully. Having a consistent point of contact who is responsible for addressing operational issues enables frontline workers to share information informally and focus their efforts on client services.
2. More opportunities for staff familiarization and interaction could ensure awareness of the Hub's overall service offerings and improve continuity of care. This could also ensure decisions and plans are communicated from leads to frontline staff and serve as a means of eliciting feedback from staff.
3. Input from community members would help to further refine service offerings and ensure local needs are met. The client focus groups, community forum, and plans for one-on-one interviews with clients that were cancelled due to COVID-19 should proceed when feasible and inform future decision making.

SUMMARY EVALUATIONS

COMMUNITY TRANSPORT PROJECT

LEAD ORGANIZATION: SOUTH RIVERDALE COMMUNITY HEALTH CENTRE (SRCHC) – HARMONY HALL

PARTNER ORGANIZATION: MGH

PROJECT LEADS: SHANNON WIENS, DAVID LIVINGSTON-LOWE

DATES: JANUARY 6, 2020 TO MARCH 31, 2020

TAKE-AWAYS

1. Evening transportation service for patients with moderate mobility needs was not cost-effective due to underutilization
2. A centralized approach to match patient need with available transportation options for inpatient and ED transitions home may be beneficial.

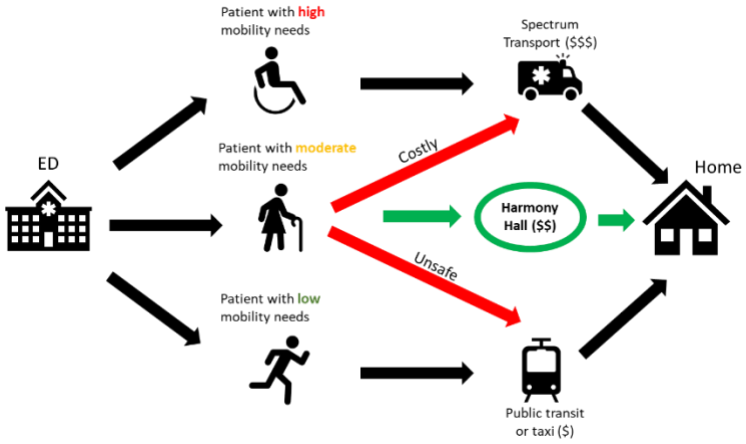
INTERVENTION

- The Community Transport project was introduced to facilitate discharge of patients with moderate mobility needs from the ED in the evening and ensure they get home safely
- It operated on weekdays from 4 p.m. to 11 p.m.
- The driver was trained to assist vulnerable persons, including individuals with moderate mobility needs.
    - The driver always aided passengers in getting in and out of the vehicle and was able to assist the patient in getting to the doorstep of their residence. (For insurance reasons, the driver could not enter their home; patients requiring in-home assistance would generally be offered a service appropriate for people with high mobility needs.)

Existing options available in the evening may not be appropriate for patients with moderate mobility needs: i.e., those who might not get home safely on public transport or in a taxi, but do not require the full services of more costly, specialized patient-transport providers.

Harmony Hall provided the service using a minivan and adapted processes that are ordinarily used for the Toronto Ride program, which provides door-to-door assisted transportation for seniors and adults with disabilities in the daytime.

Aim of the Intervention



GOALS

1. Provide safe, assisted, evening transport home for individuals with moderate mobility needs discharged from the ED
2. Reduce ED LOS by shortening waiting times for those who require assistance to return home
3. Provide a more client-centred service than a taxi
4. Reduce costs compared to private-sector patient transport or emergency-services ambulance

COSTS

Budget: $40,000 ($563.38/ride); see capacity analysis for more costing details.

WHAT HAPPENED

Process

- Harmony Hall recruited and trained a full-time driver and a part-time (0.5 FTE) dispatcher.
- The GEM team or frontline ED staff could make a request for service through a phone number for the Community Transport program
    - Patients identified by front-line staff as requiring significant mobility assistance are flagged in the electronic medical record (EMR) system for follow-up by Geriatric Emergency Medicine (GEM) team: they conduct a comprehensive assessment of the client's needs and arrange an appropriate transportation option
    - In other cases when patients need mobility assistance, frontline staff are responsible for arranging transportation
- The dispatcher worked from Harmony Hall and took calls from 4 p.m. to 7:15 p.m.; afterwards, calls were forwarded directly to the driver until the shift ended at 11 p.m.
- The driver was stationed at MGH to wait for service requests and promoted the service to ED staff while waiting

Evaluation Activities

Quantitative

- The number of service requests and trips, as well as trip times, was provided by Harmony Hall
- Cost information for alternative transportation options was provided by MGH for context and comparison

Qualitative

- The project leads participated in early-implementation and exit interviews with the evaluation team
- The evaluation team met with 4 staff at the MGH ED to gain feedback about the project and learn about processes for discharging patients
- Results of a satisfaction survey offered to passengers while in the vehicle were also shared with the evaluation team

Outputs

70 **PATIENTS TRANSPORTED**

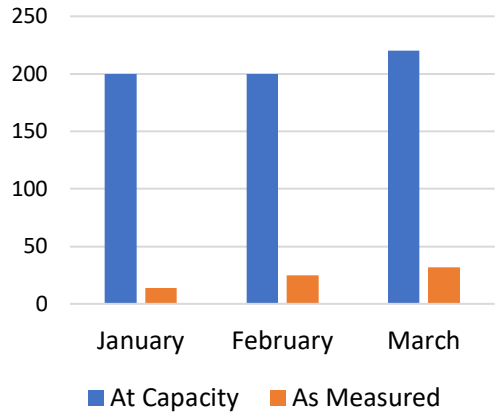
1 **WHEELCHAIR DELIVERY**

FINDINGS

Utilization versus Capacity

- Based on average trip times, the service had capacity for 8-12 trips per 7.5 hour shift, or ~50 trips per week
- The service operated at ~11% capacity (14 trips in January, 25 in February, 32 in March)
- At capacity, ~620 trips would have occurred between January 6th and March 31st

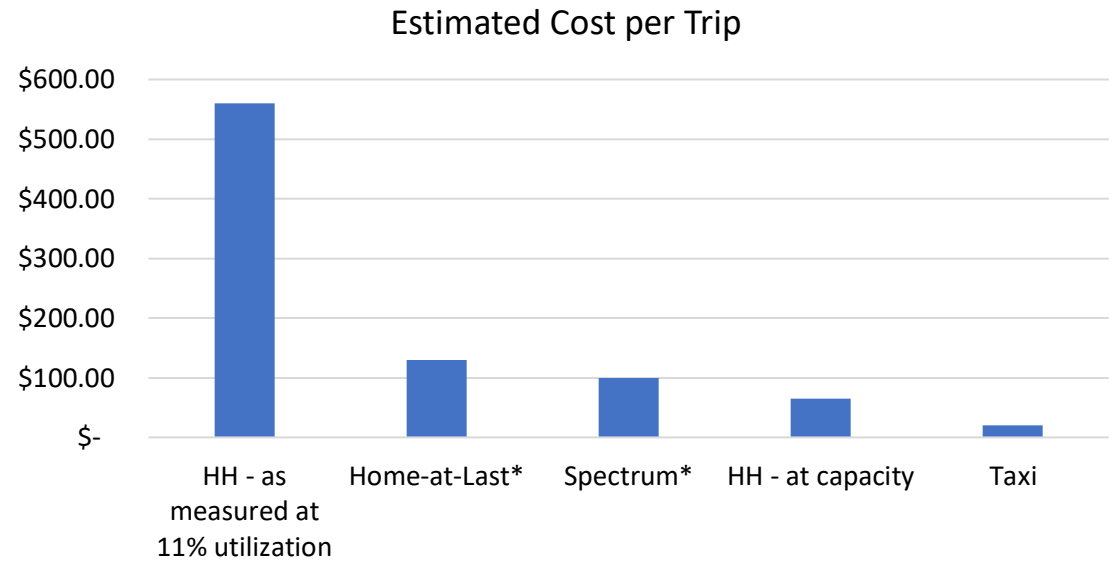
Number of trips at capacity versus actual 11% utilization



Cost Implications

Cost per trip for the Community Transport service operated by Harmony Hall (HH):

- At 11% utilization: $563.38
- At capacity: $64.52



**Home-At-Last includes transport home via taxi and 4 hours of PSW services*
**Spectrum includes 2-person assist and is appropriate for high needs patients*

Feedback

- In focus groups and interviews, low uptake of the service was attributed to:
  - Lack of knowledge among front-line ED staff;
  - Inconvenient hours of service: GEM nurses are key facilitators to discharge of many clients with mobility needs; it would be better if the service operated during the daytime (including weekend days), when they are on shift.
  - Hesitancy among front-line staff to send patients home in the evening when they haven't had a home assessment done; in some cases, this can lead to avoidable overnight stays
- The GEM team nurses and ED manager had a positive impression of the program overall. They also described it as a potential alternative to the Home-at-Last service, which operates in the daytime and always includes PSW support
  - Home-at-Last often reaches capacity by early afternoon, and cannot take requests after this time; while ED staff could put in a request to the Community Transport project for its start-time at 4 p.m., offering the service earlier could eliminate waiting time and make it a feasible option for more patients
- Of the 35 patients who completed the satisfaction survey, 100% indicated that: they appreciated the service; it was easy to use; and they would recommend it to others. Multiple clients wrote comments that they liked the driver.

Issues Identified

- The project filled a transportation gap for MGH ED patients, but was underutilized due to:
  - Lack of knowledge about the service among front-line ED staff
  - Suboptimal hours of operation (4 p.m. to 11 p.m.)
  - Lack of weekend availability
- The ED at MGH currently does not have designated personnel to handle patient discharges (other than for seniors with high needs who are seen by GEM nurses) – responsibility to determine the best method of transportation home for patients with low to moderate mobility needs is the responsibility of frontline workers

Project Outcomes

Expected Outcome	*How Did They Do?*
1. Provide safe, assisted, evening transport home for individuals with moderate mobility needs discharged from the ED	70 patients with moderate mobility needs were transported home in the evening. This is estimated to be approximately 11% capacity for the service.
2. Reduce waiting times to return home from hospital (reduce ED LOS)	According to MGH staff the service could be accessed in a timelier fashion than Home-At-Last, however there is no data available to demonstrate this
3. Improved safe, assisted transport home for vulnerable individuals discharged from hospital	Patients were transported home safely and reported satisfaction with service
4. Provide more client-centred service than a taxi	Service was more client-centred than a taxi, but the driver couldn't assist patients past their doorstep or transport wheelchair/walker bound patients
5. Reduce costs compared to private-sector patient transport or emergency-services ambulance	Due to low uptake, the service was not more cost-effective than other available options

RECOMMENDATIONS

Should this program run again?

Only if utilization can be substantially increased (i.e., by hiring dedicated staff to handle *all* discharges that involve a need for mobility assistance, including of patients not assessed by the GEM team).

If the program were to run again:

1. MGH could consider having personnel in the ED who are responsible for discharge planning for all patients in need of mobility assistance to reduce the responsibility on ED staff to retain knowledge of the various transportation options
2. To address utilization rates, the Community Transport service should start and end earlier in the day, be available on weekends, and open to access by other hospital departments

COMMITTED NON-EMERGENT PATIENT TRANSPORT (NEPT)

LEAD ORGANIZATION: MICHAEL GARRON HOSPITAL (MGH)
PROJECT LEADS: JESSICA SCOTT
PARTNER ORGANIZATION: SPECTRUM TRANSPORTATION
DATES: NOVEMBER 4, 2019 TO MARCH 31, 2020

TAKE-AWAYS

1. Demand for inter-facility transport was not as high as anticipated.
2. Most (>80%) trips were one-way trips to patients' homes (i.e., LTC or residence).
3. Other ETHP organizations also added transport services during surge. Coordinating with ETHP partners could identify which partners are best positioned to offer this type of service, resulting in more streamlined processes with better capacity to identify and respond to community needs.

PROJECT

Intervention

- MGH contracted Spectrum to provide a dedicated patient-transport truck, two-person crew, and on-site supervisor to ensure patient transport can be accessed in a timely fashion
- Spectrum transported patients from MGH to other facilities for admission (e.g., rehabilitation sites such as Providence, nursing homes) and treatment (e.g., dialysis at Bridgepoint), and from other facilities to MGH and back for acute treatment
- The dedicated truck was also used to transport patients to private residences and retirement homes if they couldn't get there at their own expense
- Service was available to all units, as well as the Emergency Department (ED), Monday to Friday, 8 AM to 4 PM.
- The target population was any MGH patient with high mobility needs identified as requiring transport, with priority for patients who need to reach another facility by a particular time

Goals

1. Ensure patients with appointments at other facilities and opportunities for hospital discharge are not missed due to transport not being immediately available
2. More patients will leave the hospital earlier in the day

COSTS

Budget: $40,000

Average cost trip: $85.84 (466 trips total)

WHAT HAPPENED

Process

- Staff responsible for discharge send transportation request to a dedicated email account
- Upon receipt of the transportation request, an MGH patient transport coordinator notifies the Spectrum supervisor, who books a time for the dedicated truck
- The staff also kept an eye out for requests that go through the usual booking process; if there is an earlier slot available on the dedicated truck, it would book be booked as an alternative
- Once a time slot was booked, the patient transport coordinator or the Spectrum on-site supervisor called the requesting unit to advise them of the pick-up time
- The Spectrum crew, consisting of a driver and assistant, transported patients directly to and from locations within facilities or into their home, using stretchers and other equipment suitable for safe transport of patients with high mobility needs

Evaluation Activities

Quantitative

- To understand how this service was used, the evaluation team analyzed billing data from MGH and Spectrum. The billing data included the day of the trip, the referring department, the destination, and the time from MGH to the destination (i.e., time in the truck).

Qualitative

- The team interviewed staff from MGH and Spectrum to get their perspectives on the service.

Outputs

466 **TRIPS CONDUCTED BY THE TRUCK**

10 **DEPARTMENTS AT MGH UTILIZED THE SERVICE**

FINDINGS

Utilization Trends

Table below displays number of trips, referring unit and the destination of the trip distributed by month for the full duration of the NEPT program.

	November	**December**	**January**	**February**	**March**	**Total**
Number of trips	101	75	134	32	124	466
Referring units	Inpatient (78.2%)	Inpatient (78.7%)	Inpatient (76.1%)	Inpatient (71.9%)	Inpatient (83.0%)	Inpatient (78.5%)
	ER (21.8%)	ER (21.3%)	ER (23.9%)	ER (28.1%)	ER (16.9%)	ER (21.5%)
Destination	**Hospital** (9.9%)	**Hospital** (9.3%)	**Hospital** (19.4%)	**Hospital** (12.5%)	**Hospital** (13.7%)	**Hospital** (13.0%)
	LTC (52.5%)	**LTC** (46.7%)	**LTC** (47.8%)	**LTC** (28.1%)	**LTC** (44.3%)	**LTC** (43.9%)
	PR (16.8%)	**PR** (24%)	**PR** (17.2%)	**PR** (28.1%)	**PR** (26.6%)	**PR** (22.5%)
	NH (9.9%)	**NH** (9.3%)	NH (10.0%)	**NH** (12.5%)	**NH** (8.0%)	**NH** (9.7%)
	RH (10.9%)	**RH** (10.7%)	**RH** (6.7%)	**RH** (18.7%)	**RH** (7.2%)	**RH** (10.9%)

ER= emergency room, LTC=long-term care, PR=private residence, NH= nursing home, RH= retirement home

Observations

- The number of trips varied significantly by month: January had the most trips (134) and February had the least (32).
- The longest trip was for 18 kilometers and lasted about an hour; the shortest was for two kilometers and lasted five minutes.
- On an average day, the truck conducted five trips.
- On the busiest day, eight trips were made. The lowest number of trips per day was two.
- More than 3/4 of requests came from inpatient units.
- 466 trips were conducted; more than 3/4 involved transport between the hospital and other facilities, while the remainder involved transport of patients to private residences.

Data was greatly comparable over the five months except for a couple of data points.

- In all the months, most referrals came from inpatient units; 22-28% came from the emergency department (ED). In March, ED referrals dropped to 17%; this may have been caused by the general reduction of patients visiting the ED due to the COVID-19 crisis.
- There was a sizeable decrease in requests February compared to the other months.
- February and March showed an increase in the number of trips with a private residence as a destination which may reflect the change that happened in the program around that time according to the program lead. However, it is worth noting that private residence as a destination was always present in the billing data (November-March).

What we heard from interviews

- Some destination facilities began to implement their own dedicated transport options during surge, resulting in less need for this program to provide inter-facility transport.

Project Outcomes

The service provided transport for 466 patients.

The stated goals of the project were to (1) Reduce number of missed appointments and Rehab bed offers related to transportation barriers and (2) More patients leave the hospital earlier in the day. Unfortunately, based on the data provided by the project team, we are unable to determine whether these goals were met.

RECOMMENDATIONS

If this project is to run again few points should be addressed:

1. Identify and assess current needs related to non-emergent patient transportation
2. Coordinate with other service-providers with similar transportation services
3. Program-specific metrics are needed to assess the impact of the project

FAST ACCESS TO REHAB

LEAD ORGANIZATION: PROVIDENCE HEALTH CARE/UNITY HEALTH

PROJECT LEADS: KELLY TOUGH, SHAWN BRADY

PARTNER ORGANIZATION: MGH ED

DATES: NOVEMBER 1, 2019 TO MARCH 31, 2020
(SURGE-FUNDED PERIOD – OPERATIONS ONGOING)

TAKE-AWAYS

1. Program was successful in increasing referrals to Providence programs
2. GEM nurses believe that the presence of a Patient-Flow Coordinator in the MGH ED allowed patients to be referred to Providence services faster
3. Project-specific metrics would enable a more thorough evaluation of the program

INTERVENTION

- A patient flow coordinator was embedded within MGH to improve awareness of Providence rehabilitation programs and services and facilitate timely transitions of patients who could benefit from their programs.
- This single point of contact for consultation and referral support facilitated direct admission to Providence inpatient and outpatient services

GOALS

1. Strengthen collaboration of care between East Toronto health providers, MGH and Providence to improve access to rehabilitation services
2. ETHP organizations will have knowledge about Providence programs & services, referral pathway (marketing & in-services) and support to problem solve options to avoid ED admissions
3. Provide faster access to rehabilitation services (inpatient and outpatient) from the MGH ED or East Toronto community.

COSTS

Budget: $53,000

WHAT HAPPENED

Process

- A Patient Flow Coordinator (PFC) was seconded from Providence to work in the MGH ED as a 0.5FTE
- The PFC provided in-services and education materials summarizing Providence programs, services and referral processes with members of the MGH ED Team (inclusive of Manager, ED GEM Nurses) and SCOPE Team (Project Manager, Nurse Manager & family physicians and family health teams)
- PFC acted as a single point of contact to facilitate direct admission from the MGH ED and admission of patients of ETHP organizations who would benefit from restorative programs

Evaluation Activities

Quantitative

- Data on patient flow between MGH and Providence were shared by Providence with the evaluation team

Qualitative

- Exit interviews were conducted with the project lead (Providence), two Coordinators, the MGH ER Manager and 3 Geriatric Medicine (GEM) nurses

Outputs

258 **ADMISSIONS TO PROVIDENCE FROM MGH, NOV. 15-MAR. 15**

31% **INCREASE OVER SAME PERIOD LAST YEAR (197 ADMISSIONS)**

FINDINGS

Perceived Process Improvements

- Faster Access: The FTE Patient Flow Coordinator noted that from the time of referral to getting the patient to Providence is much faster with engaging with the patient, family caregiver and physicians
    - Fewer staff involved in ED referrals resulted in faster connection to Providence programs
    - Improved clarity about Providence admission criteria & immediate insight into bed availability
- Improved Awareness: From the perspective of Providence and the GEM nurses, the FTE Patient Flow Coordinator brought more attention to the ED team (physicians and ED GEM nurses) about the services Providence could offer MGH.

Opportunities for Continued Outreach

- Establishing and maintaining connections with family physicians should remain an ongoing focus.

Project Outcomes

Expected Outcome	*How Did They Do?*
Strengthen collaboration of care between East Toronto health providers, MGH and Providence to improve access to rehabilitation services	Successful. MGH ED staff noted a greater collaboration, faster access to Providence rehabilitation programs. 31% increase in year over year referrals to Providence programs.
ETHP organizations will have knowledge about Providence programs & services & referral pathways	Successful. Improved awareness, faster access and improved insight into bed availability was facilitated by the onsite PFC
Provide faster access to rehabilitation services (inpatient and outpatient) from the MGH ED or East Toronto community.	Partially successful. Improved collaboration with MGH ED staff however sustained relationships with SCOPE physicians were not maintained.

RECOMMENDATIONS

- Expand outreach to the EasTFPN and SCOPE physicians to ensure they are aware of the referral criterial and programs offered at Providence.
- Surge specific metrics related to patient flow should be implemented to understand the referral patterns from inpatient, ED and EasT FPN. Referral data could be used to identify gaps in providers who can be targeted by Providence to educate them on the rehab services available.
- Opportunities to assist medically complex patients may have been missed if they were moved from the ED to other units in the hospital when the coordinator was not present (e.g., in office space on another floor). To have a greater presence of the Coordinator in the future, designated space should be made at MGH in the ED. It may be helpful to have physical space the ED so that the coordinator could work more closely with the GEM nurses.

HOMECARE SPECIALIST

LEAD ORGANIZATION: VHA HOME HEALTHCARE

PARTNER ORGANIZATIONS: MGH, SPECTRUM

PROJECT LEADS: JESSICA SCOTT (MGH), SANDRA TEDESCO (VHA), RUTH CARTWRIGHT (SPECTRUM)

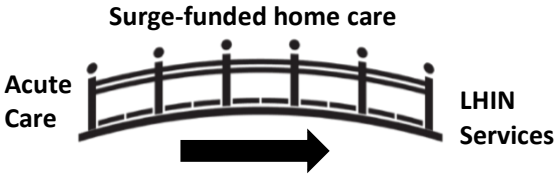
DATES: JANUARY 7, 2020 TO MARCH 9, 2020

TAKE-AWAYS

1. This project aimed to shorten hospital LOS for elderly patients by linking them with homecare services in a timelier manner than the regular LHIN process
2. Due to a lack of data it is unclear if the project succeeded in its aims, but hospital and homecare staff reported that it was useful and filled a gap in services
3. This approach to shortening hospital LOS is promising and with appropriate data collection could produce quantifiable results in future years

INTERVENTION

- This program was designed for individuals who were considered medically stable and no longer required acute care services but did require additional supports to safely return home. Referral and administrative process associated with traditional LHIN structures can introduce delays to hospital discharge.
- During the winter surge season these referral processing delays can have a significant impact on patient flow within the hospital.
- To address delays related to transitions home two 'homecare experts' were embedded within the hospital to provide homecare-specific transition planning and facilitate direct access to homecare service providers for fast access to homecare.
- One nurse from each service partner organization (SPO), VHA & Spectrum, filled the role of HomeCare Specialist (0.5FTE) to support transitions home through daily participation in MGH interdisciplinary rounds which focused on transitions & discharge planning.
- HomeCare Specialists at each SPO facilitated direct referrals, to either organization, to initiate same day or next day services for medically stable individuals who could safely return home with supports. Spectrum typically provided PSW support while VHA was more likely to provide rehabilitation and extreme cleaning services.
- These services were expected to be temporary assistance until LHIN funded supports could be arranged through the standard referral process. It was expected that these temporary or bridging services would last between 2-14 days.



GOALS

1. Shortened hospital LOS for frail elderly
2. Better continuity of care from hospital to home
3. Better matching of services to patients' needs

COSTS

Budget: $260,000; approximately $3,824/client

WHAT HAPPENED

Process

1. Patient is identified as able to return home, but in need of home care, during rounds (by MGH care coordinator/TN)
2. If the LHIN is unable to provide the needed services within the timeframe required, the MGH coordinator communicates with the on-site HomeCare Specialist
3. The HomeCare Specialist reviews patient information and the ability to meet the patient's needs through their organization
4. A service plan is created to meet the patient's needs at home in the next 2 days to 2 weeks
5. The patient is transitioned home (accompanied by PSW in some cases)
6. As the bridging service comes to an end, the home care organization ensures that the patient is connected to on-going home care through the LHIN or other community programs as needed

Evaluation Activities

Quantitative

Data was provided by each SPO summarizing the number of individuals who received services, types of services received, and where available, if ongoing LHIN services were put in place.

Qualitative

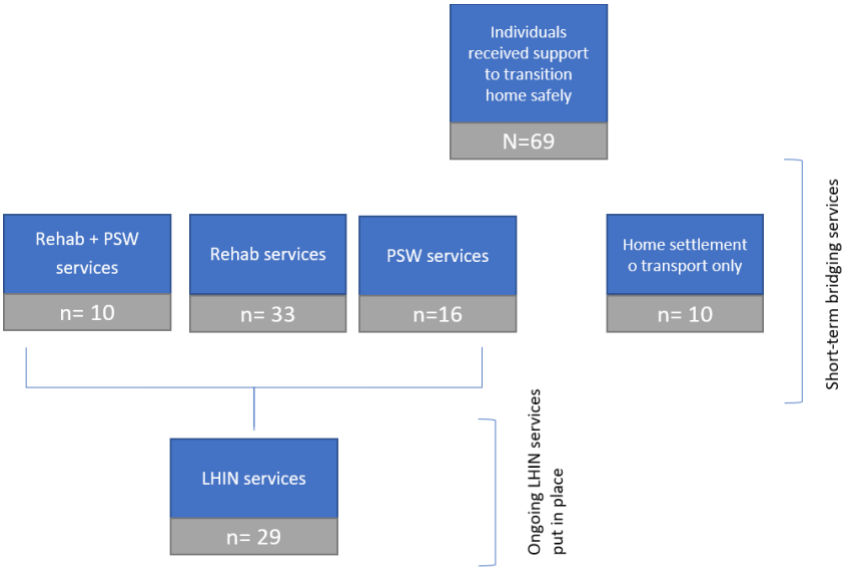
A focus group was conducted with six individuals who had direct knowledge of the HomeCare Specialist Program including the MGH Transition Navigators, Project Managers and HomeCare Specialists from each of the homecare organizations.

A separate interview was conducted with the leads from each of the organizations (MGH, Spectrum & VHA).

Outputs

69	**CLIENTS RECEIVED SUPPORTS TO TRANSITION HOME**
10	**RECEIVED REHAB + PSW SERVICES**
33	**RECEIVED REHAB SERVICES ONLY**
16	**RECEIVED PSW SERVICES**
10	**RECEIVED PSW SETTLEMENT OR TRANSPORT ONLY**
29	**RECEIVED ONGOING LHIN SERVICES**

Patient Flow



Service Recipients	69
Provider	
Spectrum	26
VHA	43

Patient Characteristics

- Clients were mostly elderly, majority over the age of 80
  - 25 of 69 were 80-89
  - 12 of 69 were 90+
- Clients lived in many different East Toronto neighborhoods

FINDINGS

Interviews were used to understand the perceived impact of the project. The available quantitative data provided insights into utilization but was not sufficient to assess overall outcomes and success.

Perceived Outcomes

- Bridging service adds assurance that patients will receive the homecare services they need when they need them
- According to Homecare Specialists and MGH staff patients benefited from this initiative by being able to:
  - return home sooner
  - communicate with home care staff directly on site at the hospital: no waiting for LHIN call back
  - have full continuity of care (e.g., PSW may accompany them home from the hospital)

These outcomes were believed to improve trust in the healthcare system and increase patient satisfaction.

Selected Quotations

Benefits for Patients	"The other benefit might be having direct contact with someone from the service-provider company – it contributes to continuity of care. Rather than having referrals sent off by the TNs, and then being assigned a service provider later on, a TN can actually introduce them to the PSW who'll be taking them home, or bring in a coordinator from the agency that will be sending workers to their home for the bridging period." — MGH Staff
Coordination between Homecare Orgs	"Given the PSW shortage, the redundancy is seen as beneficial. For example, if [the VHA Homecare Specialist] receives a request for PSW services and VHA cannot fulfill it, she can check with [the Spectrum Homecare Specialist] if Spectrum has PSW capacity at the moment." – Homecare Specialist
Lack of Access to Hospital Data	"One thing that can be difficult, though, is we don't always have all the information that would be helpful. Like, as outside service providers, we don't have direct access to the hospital computer systems, of course. So we're working with the information that's on the paper charts on the unit, and what we can gather from the TNs and clinicians and patients and family members." – Homecare Specialist
Coordination with LHIN	"For this initiative, we only use it if the LHIN can't put supports in place right away… Now the thing is, though, I'm not sure who's talking to the LHIN – I hand it off to the homecare specialist for bridging support, and they're discharged, but we need to let the LHIN know the situation so they can coordinate over the longer term." – TN

Project Outcomes

Expected Outcome	*How Did They Do?*
Shortened hospital LOS for frail elderly	Detailed data required for this level of analysis was not available. Same day or next day PSW or Rehab service delivery was experienced. Quick Access teams were created by each SPO to provide fast access.
Better continuity of care from hospital to home	PSWs accompanied the patient home from the hospital, rather than the patient returning home on their own
Better matching of services to patients' needs	Focus group data suggested that negotiations related to service requests were not experienced in the bridging program. Decisions related to service need were made by the team collaboratively with the TN and Homecare Specialists.

RECOMMENDATIONS

Should this program run again?

Unfortunately, sufficient data was not available to determine whether this program was successful. Based on interviews, this project appears to have contributed to timelier transitions home for some patients. However, given the lack of data provided it is not possible to determine whether the program was successful overall.

If this program were to run again, what changes should be made?

If run again, more documentation and metrics must be collected and provided to the evaluation team. To enable calculation of shortened hospital LOS we would need (for each patient):

- date of LHIN referral and referring organization (MGH or homecare organization),
- services requested,
- services offered by LHIN,
- proposed date of LHIN-funded service initiation,
- date of hospital discharge,
- date of surge-funded service initiation,
- date of LHIN-funded service initiation (if applicable)

This data would allow us to estimate gaps in service and differences in hospital LOS.

Additionally, processes should be in place so that the homecare specialists can access relevant MGH patient data, so they are able to work more efficiently and access necessary patient information to understand and meet their needs. Qualitative interviews with patients could also be implemented to gather information on their perceptions of the Home Care Specialist role and patient-related outcomes such as 1) education around home care services 2) perception of match with their service needs.

WALK-IN COUNSELLING DURING "12 DAYS OF HOLIDAYS"

LEAD ORGANIZATION: WOODGREEN COMMUNITY SERVICES

DATES: DECEMBER 23 & DECEMBER 30, 2020

PROJECT LEAD: JULIA CHAO

TAKE-AWAYS

1. Two days of walk-in counselling was made available during the holiday season.
2. As a small-scale effort, this initiative reached 10 clients.
3. A broader initiative in which more mental health services at more locations remain open throughout the holiday season may result in reduced mental-health related ED traffic.

INTERVENTION

- 30 walk-in sessions were made available over the holidays to extend WoodGreen's existing Walk-in Counselling (WIC) service
- Targeted to adults experiencing isolation, stress, anxiety and/or food insecurity; Intended as an alternative to visiting a hospital emergency department
- Services were provided by volunteers, who received meals and a $15 gift-card as an honorarium

GOALS

1. Increase access and use of walk-in counselling over the holiday season
2. Divert individuals from hospital through proactive supports in the community
3. Address immediate food insecurity needs among those accessing the clinic

COSTS

Budget: $3,000 ($927.90 spent)

WHAT HAPPENED

Process

- WoodGreen advertised the initiative and invited volunteer counsellors to participate
- Walk-in counselling was available on December 23 and 30 from 4:30 p.m. to 8:30 p.m.
- Clients who identified as experiencing food insecurity issues received grocery gift cards

Evaluation Activities

Quantitative

- A report on service utilization and expenditures was provided to the evaluation team for analysis

Qualitative

- An exit interview was conducted with an executive, a manager, and the clinical supervisor for walk-in services at WoodGreen

Outputs

10 **CLIENTS RECEIVED SERVICES**

8 **CLIENTS RECEIVED GROCERY GIFT CARDS**

FINDINGS

- Of the 10 clients that received counselling services on each of the 2 dates of the program
  - 4 were new clients
  - 6 had attended before
- 30 counselling slots were available; the initiative operated at 1/3rd capacity
- There is no direct evidence that this project diverted ED traffic since we do not have records linking the individuals who received WIC services to future trips to the ED and none of the service recipients identified the ED as the place they would have gone if the WIC service had not been available.
- Relatively low client numbers (10 of 30 available client slots were used) can be attributed to a) natural fluctuations, as the clinic can receive anywhere between 5 and 25 per day during normal operation, or b) a lack of awareness about the clinic being open.

Project Outcomes

Expected Outcome	*How Did They Do?*
Increase availability and service usage of walk-in counselling over the holiday season	One clinic was open for two additional days over the holiday season.
Divert individuals from hospital through proactive supports in the community	It is unknown if any ED traffic was diverted as a result of this initiative.
Address immediate food insecurity needs among those accessing the clinic	Those who visited the clinic who were identified as having food insecurity were provided with a grocery gift card.

RECOMMENDATIONS

In future years:

1. The initiative has potential to create a more noticeable impact on ED traffic if it exists on a larger scale with more available times/dates/sites open and a higher level of awareness in the community about the service being available and open during the holidays.
2. It would be ideal if WIC client records could be linked with ED records to determine whether those who used the WIC service later visited the ED for mental health or food insecurity reasons during the holiday season.
3. It would be ideal to have access to all mental health and food insecurity related ED visits over the holiday season to compare years where the WIC service was not available to years when it was.

THORNCLIFFE PARK WINTER AFTER-HOURS CLINIC

LEAD ORGANIZATION: HEALTH ACCESS THORNCLIFFE PARK (HATP)

PROJECT LEADS: DR. CATHERINE YU, MIRA DODIG

DATES: DECEMBER 2, 2020 TO MARCH 7, 2020

PARTNER ORGANIZATIONS: TORONTO HEALTHCARE CENTRE (THCC), DR. MICHAEL CHU, MICHAEL GARRON HOSPITAL (MGH)

TAKE-AWAYS

1. The clinic saw 846 patients, a 50% increase in patient visits compared to a similar Surge initiative last year
2. The clinic provided a valuable access point for some patients to receive unique services or referrals that would not ordinarily be available in a walk-in setting
3. Impact on Emergency Department (ED) utilization could not be determined precisely, however patient-reported data indicates at least 15 per cent of visits to the clinic avoided a visit to the ED

INTERVENTION

- After-hours clinic aimed at providing high-quality primary care in Thorncliffe Park, a lower-income neighbourhood with a high proportion of newcomers to Canada, saw 846 patients in 96 clinic days
- Services addressed unique community needs and challenges through its capacity to serve uninsured persons (12% of patients seen), provide translation services, and connect patients with allied health services
- To ensure continuity of care, notes were sent in all cases where a patient was rostered with a primary care physician (86% of patients); other patients were offered options for primary care attachment in the neighbourhood
- Salaried funding model ensured group-practice physicians were not negated when their patients accessed the clinic on a walk-in basis
- Referral pathways for follow-up care and strategies to divert frequent ED users to the clinic were developed and promoted through collaboration with MGH
- Space and administrative support provided for the SCOPE Mental Health program, which enabled people to receive brief counselling in the Thorncliffe Park neighbourhood after-hours

	Clinic Open (96 days)
Monday-Friday	5 p.m. to 9 p.m.
Saturday & Sunday	10 a.m. to 4 p.m.
**Closed on Dec. 25, Jan. 1 and Feb. 17*	

GOALS

1. Improve access to high-quality after-hours primary care in the Thorncliffe Park community
2. Alleviate pressure on the Emergency Department at MGH
3. Ensure continuity of care through communication with primary care providers
4. Connect unattached patients with primary care and allied health services

COSTS

Budget: $112,000
Cost per clinic visit: $131.92 ($112,000/846 visits)

WHAT HAPPENED

Process

- Clinic established in HATP's space in the East York Town Centre, a central location in the Thorncliffe Park neighbourhood
    - Last year, a similar initiative was established with Surge funding to address a disruption in availability of after-hours primary care due to a fire at a major clinic. While these services have been re-established, clinicians in Thorncliffe Park identified a need for expanded capacity and availability of HATP's comprehensive service offerings after-hours during Surge season
    - HATP was responsible for program design, clinic space, care coordination, scheduling and administrative support
    - THCC was responsible for accounting and project management
    - Partnerships with THCC and Dr. Michael Chu's office were leveraged for physician recruitment and promotion
- Physicians provided primary care in a model including comprehensive services such as connection of uninsured, unattached, or complex patients to appropriate health services
    - A salaried funding model that avoids negation of group-practice physicians aligns with HATP's broader efforts to engage physicians who serve Thorncliffe Park in a community of practice and ensure local needs are identified and met systematically
    - Ordinarily, group-practices with operations in Thorncliffe offer after-hours services at other sites at a considerable distance from the neighbourhood, while walk-in clinics nearby do not have the capacity to consistently follow up with primary care providers or fully address the needs of complex patients
- Clinicians prepared encounter notes for each visit, which were forwarded by reception staff to primary care practices where patients were rostered
- Patients in need of primary care attachment or allied health services were identified by clinicians for follow-up by HATP care coordinators
    - HATP can immediately roster patients who fall under its mandate to serve uninsured and complex patients
    - Other unattached patients were rostered by physicians staffing the clinic or given information about nearby clinics accepting new patients
- Referrals were made to allied health services delivered through HATP (e.g., care-navigation services, social work, diabetes management)

Evaluation Activities

Quantitative

- De-identified data on each client encounter and relevant data extracted from clinician notes were analysed by the evaluation team
- Results of a patient survey implemented by the clinic (response rate: 87%) were also analysed.

Qualitative

- Intake and exit interviews were conducted with the project leads.

Outputs

846 PATIENT VISITS

26 PATIENTS REFERRED FOR ROSTERING

7 REFERRALS FOR HATP ALLIED HEALTH SERVICES

FINDINGS

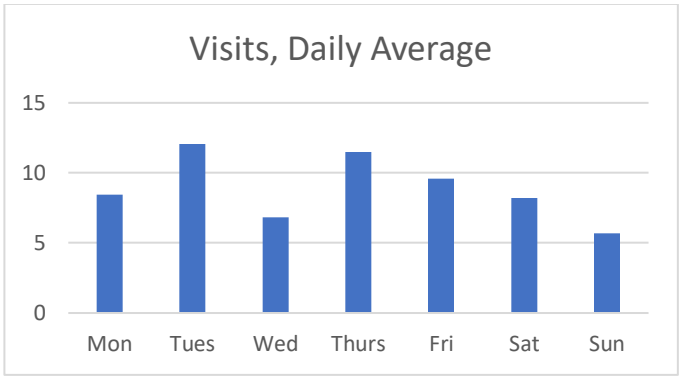
Patient Characteristics

- Nearly all patients came from Thorncliffe Park or nearby
  - 59% came from the Thorncliffe Park postal district (M4H)
  - A significant majority of the remainder came from adjacent postal districts
- 100 patients (12%) were not insured
  - A further 22 (3%) had Interim Federal Health (IFH) coverage, which can be a barrier to access in some primary care settings
- 152 patients indicated they were unattached to primary care
  - 26 complex or uninsured patients were referred for rostering at HATP
  - Other patients could be rostered to physicians' regular practices or referred to clinics nearby with capacity for new patients, however data on this type of referral is not available
- 12 patients presented with conditions that led to referral *to* the Emergency Department

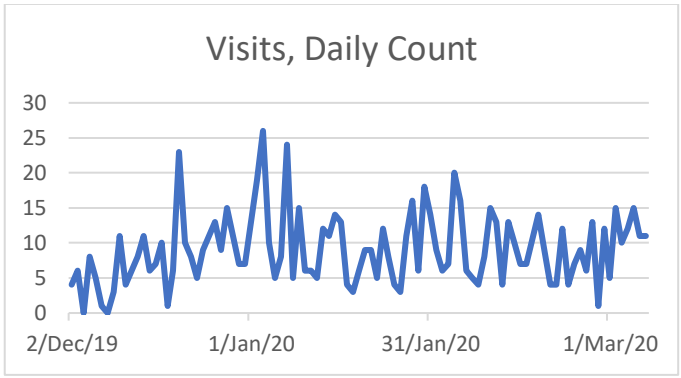
Utilization Trends

- On average, the clinic saw 1.97 patients per hour, however there were significant differences between utilization on weeknights versus weekdays (see below).
- Aside from a modest increase in the first few weeks of the intervention, there were no significant changes in utilization over time.

Visits, Average by Weekday



Visits, Daily Count



Weeknights vs. weekdays

- It was anticipated there would be higher demand for services on Saturdays and Sundays, as primary care practices are often closed on weekends
- Physicians were scheduled for 4-hour shifts
    - 1 shift per weeknight
    - 2 shifts per weekend days, with double coverage from noon to 2 p.m.
- Utilization data indicates demand was actually lower on weekends; physician resources were therefore used more intensively on weeknights than on weekends

	Hrs. Open	MD Hrs.	Pts./Day	Pts./MD hour
Monday-Friday	4	4	9.6	2.4
Saturday & Sunday	6	8	7.0	0.9

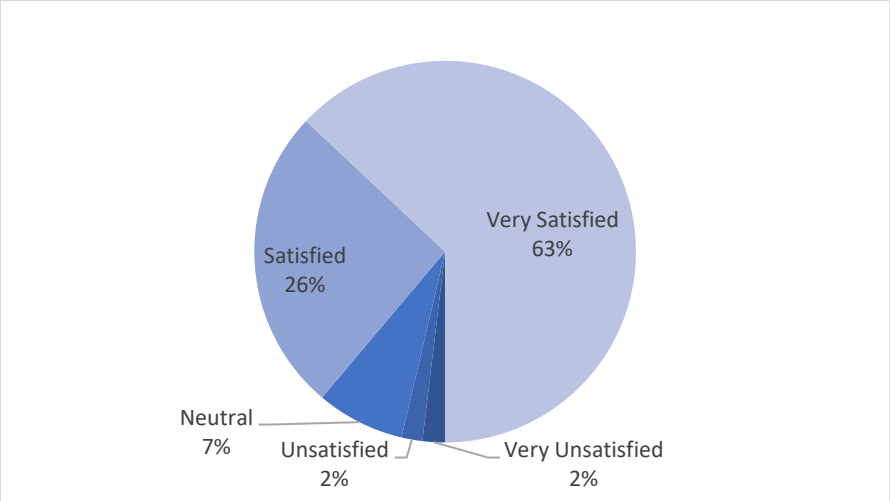
ED Avoidance

Several measures were used to estimate the extent to which the clinic prevented avoidable ED utilization.

- The patient survey the question asked: "If this clinic had not been open for your visit, what would you have done?" (circle one of the following). Of 6 options presented (including 'other'), 15% of respondents circled 'Gone to the Emergency Department of a nearby hospital (e.g., Michael Garron Hospital)" as the only option; a further 3% circled multiple options, including hospital.
    - Extrapolating from patients who answered this question (726) to all patients seen (846), an estimated 127 visits to the emergency room were avoided (patient circled 'hospital' only); a further 25 visits were possibly avoided ('hospital' among several options circled).
    - Given that this question asked patients about their intentions at the time they were seeking care, it is likely the most reliable estimate of how many ED visits were actually avoided.
- Standardized notes completed by physicians included a scale (0-5) to estimate the extent to which they perceived an ED visit was avoided for each patient they saw. Physicians indicated '3-probably' or higher for 71% of visits and indicated '4-very probably' or '5-definitely' for 59% of visits.
    - In an exit interview, the project lead suggested the relatively high estimates by physicians could be attributed to the question being interpreted as asking whether the patient's condition might have required emergency care if no other options were available. A complementary interpretation is that the question for physicians was focused on the emergency department, whereas the patient survey presented a variety of options to consider.
    - As such, this measure indicates physicians perceived that urgent care was appropriate for the considerable majority of patients they saw, however it may not be as reliable as an indicator of whether patients actually used the clinic as an alternative to the ED.
- Responses to the survey question, "where did you hear about the clinic" included an option to indicate "hospital". This can be seen as a proxy measure of efforts to promote the clinic at the MGH ED as an alternative for regular users and patients needing follow-up care. Only 7 patients (0.8%) indicated "hospital", suggesting these efforts did not have a significant impact.

Patient Satisfaction

The patient survey asked patients to rank their satisfaction with their visit on a 5-point scale. Of the 735 per cent of patients who answered this question, 89% indicated 'satisfied' or 'very satisfied'.



ED diversion pathways

- Last year, HATP's winter walk-in clinic focused on establishing relationships with local physicians and awareness of HATP's services. This year the intention was to build on this work by liaising with the MGH Emergency Department to establish pathways for:
    - Referring patients who use the ED for primary care (i.e., providing a 'medical home' in the community during Surge season, with capacity to connect patients to long-term primary care arrangements)
    - using the clinic to remove barriers to discharge and prevent repeat visits (i.e., by including community after-hours services in discharge care plans);
- The clinic was promoted in Emergency Department staff meetings and through pamphlets;
- However, the clinic did not receive many referrals from MGH (7; 0.8% of all patient seen)
    - The lead noted that the ED serves a very wide geographic area, and only a minority of its patients reside in or near Thorncliffe Park; the pathways being offered by HAPT are only relevant to a small number of cases, and frontline ED staff may not retain knowledge of them
- From the leads' perspective, for hospital-to-community referral pathways to be used consistently and effectively reduce pressure on the ED, similar services to HATP's would need to be in place in every district
    - This year's efforts to discuss logistics and identify challenges could inform future work organized through Ontario Health Team initiatives, in particular to build hubs with offerings similar to HATP's in all districts of the east end
    - The leads' expectation is that more referrals would flow from hospital to community clinics as comprehensive service models become more widespread

Referral to Local Health Services

- HATP included referral and rostering in the after-hours service as part of its mandate to provide comprehensive services. However, in practice:
    - The considerable majority of patients were already rostered with a primary care practice and were visiting for a one-time concern
    - As such, direct inter-professional referrals were not seen as a primary aim for this year's after-hours clinic, and are unlikely to be prioritized in future initiatives
- To facilitate referrals when needs were identified, HATP care coordinators were available to support the program on a part-time basis
    - Most referrals were for primary care attachment (26)
    - 7 referrals were made for inter-professional services at HATP, which is consistent with low numbers last year
- The lead suggested that physicians may be unlikely to make direct referrals for allied health services in a clinic where most patients receive services on a walk-in basis
    - Generally, physicians' preference would be to communicate the need for allied health to a physician with whom the patient is rostered, who could then handle referrals – and to prioritize primary care rostering if the patient is unattached

Project Outcomes

Expected Outcome	*How Did They Do?*
Improve access to high-quality after-hours primary care in the Thorncliffe Park community	• Successful in providing primary care services to 846 patients: 50% increase compared to a similar intervention last year • Comprehensive service model creates capacity for higher-quality care than standard fee-for-service walk-in clinics • High patient-reported satisfaction (89%)
Alleviate pressure on the Emergency Department at Michael Garron Hospital	• Unable to determine.*
Ensure continuity of care through communication with primary care providers	• Encounter notes were successfully sent in 100% of cases where the client was rostered with a primary care provider
Connect unattached patients with primary care and allied health services	• Successful in ensuring consistent capacity to roster complex and uninsured patients, and refer any patient in need of allied health services to HATP • While only a small minority of patients were identified as needing these services, referrals were made in cases where needs were identified, enabling patients to access services that wouldn't otherwise be available locally

** Patient- and physician-reported perceptions of whether ED visits were diverted suggests some impact, however there is significant variation in these metrics (see above). Strategies to assess impact from the MGH perspective at endpoint were precluded by the COVID-19 response.*

RECOMMENDATIONS

1. Adjust resource allocation to better align with demand

   This year's initiative demonstrated demand for additional after-hours services in Thorncliffe Park during Surge season, given that volumes increased by 50% compared to last year. However, the large discrepancy between the rate of patients seen per physician, per hour, between weeknights (2.4) versus weekends (0.9) suggests there is less demand than anticipated on weekends. This could be addressed by eliminating the 2-hour overlap of physician shifts and possibly reducing hours of service on weekends.
2. Continue efforts to build volumes without compromising quality of care

   While the Thorncliffe model is specifically designed to meet the needs of patients who would not receive optimal care at standard walk-in clinics – and therefore often requires more physician time per visit – utilization data and exit interviews suggest that the clinic still has capacity to serve more patients. To build on the increase in volumes seen this year, future initiatives could:
   - Continue building partnerships and engaging in direct outreach (posters, fliers, etc.), especially in languages other than English
   - Ensure promotional materials emphasize that translation and services for uninsured persons are available;
3. Continue working with health-system partners to develop hospital-to-community referral patterns and ED-avoidance strategies throughout East Toronto
   - This could address the limitations identified this year by trying to do this for one location only, and ultimately make a broader impact
   - Planned work for local hubs throughout east Toronto could draw on the work completed by HATP for this year's initiative

PAEDIATRIC SHORT-STAY UNIT

LEAD ORGANIZATION: MICHAEL GARRON HOSPITAL (MGH)

DATES: NOVEMBER 11, 2019 TO MID-MARCH, 2020

PROJECT LEADS: SHELLEY DARLING, DOROTHY QUON

TAKE-AWAYS

1. Diverting patients from the Emergency Department (ED) to the paediatric unit for short-stay observation had negligible impact on ED workload, but was perceived by clinicians as improving patient experience
2. The service, staffed by a full-time RPN had at least 25 days with no patients in its 96 days of operations, and saw an average of approximately 1 patient per day
3. Changes to program design and referral pathways could potentially broaden impact without extra resources

INTERVENTION

- Pathway targeted to paediatric patients who present at ED and require time for observation and follow-up to be transferred to the paediatric unit (G7) for a short stay (intended to be less than 6 hours)
- Identified as a potential means of shifting workload from the ED to the paediatric unit, given that the latter often operates below capacity on evenings
- Informed by learnings from last year's Adolescents, Babies, and Children (ABC) Clinic Surge initiative
    - The ABC clinic saw relatively low volumes and lower-acuity patients, and was therefore not perceived as having a significant impact on ED workload
    - However, the ABC clinic also had very positive feedback – including 100% satisfaction on a caregiver survey – and led to a modest reduction in average LOS
- The PSSU was intended to have a greater impact on relieving ED workloads while preserving two key aspects of the ABC clinic that were perceived as key to achieving caregiver satisfaction and high-quality patient care:
    - Specialist attention from a paediatrician
    - A quiet, child-friendly location away from the ED (which staff describe as often hectic, and not optimal for children)

GOALS

1. Reduce overall length of stay (LOS) for paediatric patients
2. Improve the experience of paediatric patients and caregivers
3. Relieve workload on the Emergency Department (ED)

COSTS

Budget: $36,000

Cost per patient: $391.30 (confirmed or probable – see note below)

WHAT HAPPENED

Process

- RPN seconded to the Paediatric Unit to receive short-stay patients referred from the ED
- Suitable patients were identified by ED staff and handed-off to the PSSU RPN
- The RPN monitored patients and coordinated assessment and follow-up care with the paediatrician on-call
- Typically, patients spent 2-5 hours in the ED, followed by 1-4 hours in the PSSU

Evaluation Activities

Quantitative

Unfortunately, there is no precise count of PSSU patients. While MGH configured its records system to track PSSU patients, due to logistical issues, this mechanism was not used consistently. As a workaround, an MGH data analyst conducted a retrospective analysis of hospital EMR data and a paper log-book from the PSSU, which was provided to the evaluation team for analysis.

Qualitative

An exit interview was conducted with the Manager, Emergency Department & Medical Short-Stay Unit. Planned focus groups and interviews with frontline staff and Paediatric leads had to be cancelled due to COVID-19. Key points from the interview were sent by email to the intended participants, inviting feedback or alternative interpretations; no responses were received.

Outputs

The retrospective data analysis provided the following measures:

- 63 'confirmed' patients were recorded in a paper log-book for PSSU encounters;
- 29 'presumed/likely' patients were not recorded in the log-book but had 'for PSSU' indicated in the 'ED location' field of the EMR, and fit the admission profile consistent with PSSU patients: i.e., arrival time when the PSSU was open, and a length of stay consistent with that of PSSU patients;
- 64 'possible' patients had either 'for PSSU' indicated in the 'ED location' field, or the patient record fit the expected admission profile.

'Confirmed and presumed patients' – 92 total – would appear to be the most reliable estimate. With 'presumed' patients, the 'for PSSU' note in the EMR and alignment with the time-period when the PSSU was operating suggests it is likely that the patient was routed to the PSSU.

While some actual PSSU patients may be missed by the 'possible' estimate, there is less evidence to confirm patients with this profile actually had interaction with the PSSU.

~92 PATIENT VISITS (CONFIRMED OR PRESUMED)

96 CLINIC DAYS

~1 AVG. PATIENTS PER DAY (CONFIRMED OR PRESUMED)

FINDINGS

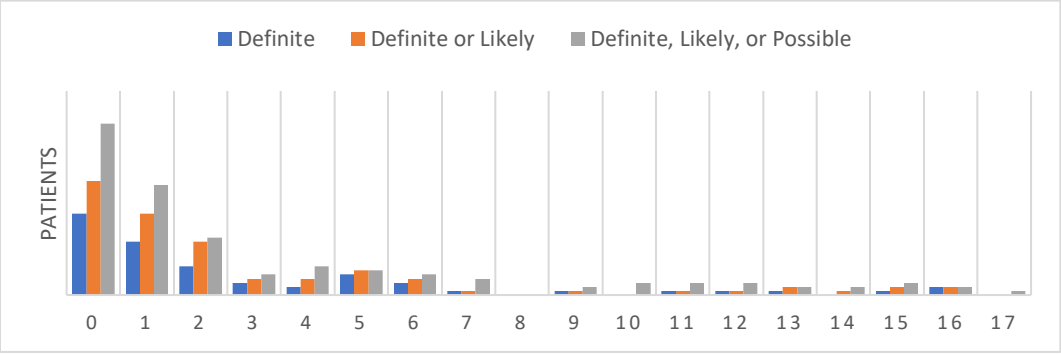
Availability and uptake

- The PSSU was available on 96 days, and saw approximately 91 patients (confirmed and presumed)
- On 65 days, no confirmed patients were recorded; on 51 days, no confirmed or presumed patients were recorded; and on 25 days, no patients in any category were recorded
    - As such, there were at least 25 days on which the PSSU was available and definitely saw no patients; and it is likely that no patients were seen on nearly half the days the PSSU operated.
- On average, the PSSU saw approximately 1.0 patients per day (0.7 confirmed; 1.6 if 'possible' patients are included).
- On days when the clinic did see patients, the number was typically 1-3 (confirmed or presumed).
    - The only exceptions are one day on which 4 confirmed and presumed patients were seen, and one day on which 8 such patients were seen.
- Compared to last year's ABC clinic, the volume of patients was lower (169 confirmed for ABC clinic; 91 confirmed or presumed for PSSU)
    - This may be due to the difference in mandate: the ABC Clinic was primarily for brief assessment, while the PSSU was designed for observation and follow-up

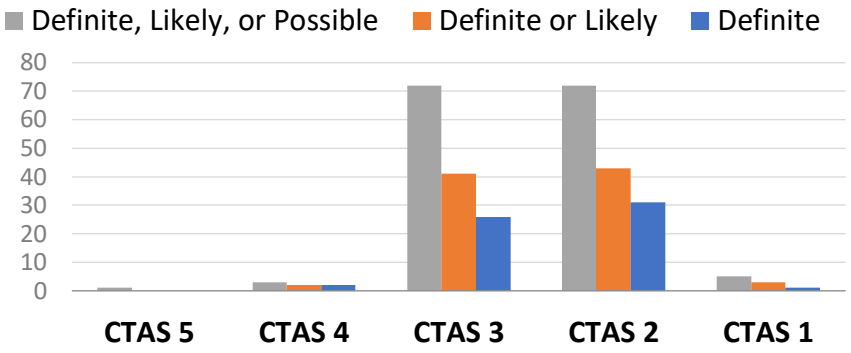
Patient Characteristics

- Nearly all patients seen were triaged as CTAS 2 or 3
- While the PSSU could see patients up to 17 years of age, the significant majority were under 3 years old, and many were infants
- Based on a partial dataset (to February 26), the clinic treated a relatively wide range of conditions
    - Fever was the most common condition treated (28% of cases)
    - Cough-congestion (15%) and abdominal pain (12%) were the only other conditions that accounted for more than 10% of cases
- While the PSSU was intended for *short* stays by patients who would normally be treated in the ED, approximately 15% of patients routed to the PSSU became "true admits" – i.e., were hospitalized for more than 6 hours or stayed past midnight
    - While most patients of last year's ABC clinic were also triaged as CTAS 2 or 3, very few, if any, became 'true admits' – the fact that approximately 15% of PSSU patients became 'true admits' suggests the PSSU saw a subset of higher-acuity patients who wouldn't have been routed to the ABC clinic

Patient Age



PSSU Patient Acuity



Impact on Length of Stay

It is not clear if the PSSU had any impact on overall length of stay (LOS) for paediatric patients

- The clinic's average volume of 1 patient per day was too low to free up resources to reduce LOS among ED patients in general, including paediatric patients (see 'Feedback from ED' below)
- Given that PSSU was targeted for patients identified as needing extra time for observation or follow-up, reducing LOS for these patients may not align with their medical needs
    - These patients may still experience avoidable waiting times, however more granular data and analysis would be needed to distinguish avoidable waiting times from time required for clinical observation
- Project leads noted that while the PSSU could generally assess and discharge patients who require observation more quickly because it is less busy than the ED, in some cases, patients might have to wait longer as the sole physician on the paediatric unit may be attending to other duties

Feedback from the ED

- Volumes were not high enough to have an impact on ED workload
- ED staff were generally supportive of the initiative given its perceived benefits for paediatric patients and caregivers
- The staffing model was not perceived as optimal
    - Given that the RPN seconded from the ED treated a lower number of patients (often 0 per evening) compared to an RPN working in the ED, concerns were raised by some ED staff about this allocation of resources
    - RPNs based in the ED have limited experience and comfort treating infants. The RPN consulted with RNs on the paediatric unit, however there were still some challenges given that they do not normally work together
    - From the ED perspective, ideally the PSSU could operate as a subcomponent of the paediatric unit, which would not require extra resources
- The ED manager suggested that referral pathways from beyond the ED could increase volumes and broaden the impact of hospital-based paediatric after-hours services
    - A standalone program could potentially receive referrals directly from primary care physicians, as well as the ED – enabling more patients to access paediatric specialists
    - This suggestion was also made last year through feedback from clinicians about the ABC clinic
    - In discussing alternative pathways, MGH staff have consistently noted that patients should still be assessed by primary care physicians or at the ED prior to referral to the paediatric service

Project Outcomes

Expected Outcome	*How Did They Do?*
Reduce overall length of stay (LOS) for paediatric patients	Unable to evaluate.
Improve the experience of paediatric patients and caregivers	While experience was not formally evaluated, feedback from staff and the project's key components – moving patients to a less hectic environment and providing assessment by a paediatric specialist – suggest success in improving experience compared to a standard ED visit.
Relieve workload on the Emergency Department (ED)	Low utilization and feedback from the ED indicate the intervention did not have an impact.

RECOMMENDATIONS

1. It may be worth revisiting the aim of targeting paediatric patients as a means of reducing overall ED workload

   Two different interventions in successive years (ABC and PSSU) were intended to have this effect and had a negligible impact.

   The aims of improving patient and caregiver experience might be achieved by program changes in the paediatric unit that don't involve drawing on resources intended to relieve pressure on the ED.

2. A standalone short-stay unit/program with mechanisms for referral from primary care providers could extend availability of specialist resources and possibly avoid use of the ED, while still receiving patients that do present at the ED

   However, given that the most common conditions seen at the PSSU (fever, coughs, etc.) are often treated in primary care settings, it may also be worth exploring further strategies to encourage caregivers to simply access treatment at locations other than the hospital

3. Reliable data collection would be crucial to evaluating any future efforts to meet the goals of this program:
   - A consistent count of patients is essential to accurately assessing utilization, impact, and cost implications
   - Feedback from caregivers (e.g., a survey) and the paediatric unit would be helpful in assessing perceived impact

HEALTH BOOST INITIATIVE

LEAD ORGANIZATION: WARDEN WOODS COMMUNITY CENTRE (WWCC)

PROJECT LEADS: GINELLE SKERRITT, PARVEEN AMLANI

DATES: JANUARY 7, 2020 TO MID-MARCH 2020

PARTNER ORGANIZATIONS: AFGHAN WOMEN'S ASSOCIATION, EAST END COMMUNITY HEALTH CENTRE

TAKE-AWAYS

1. Pilot health-promotion initiatives targeted to marginalized and vulnerable populations reached a total of 49 individuals through 4 sub-programs
2. Outreach and partnership-building were key components of the initiative; these activities took more effort and yielded fewer results than anticipated
3. The impact of the pilot initiatives was limited by timeframe, logistical issues, and the fact that the program aimed to address needs that exist year-round

INTERVENTION

- Health-promotion activities for communities identified as having high needs related to nutrition and healthy living that are not addressed effectively by standard, population-wide health-promotion strategies
- Activities were targeted to specific populations: 1) people living in poverty, including those who are homeless, and 2) immigrants, especially newcomers. Most programs were also available to the general community
- A registered nurse (RN) and worker with a harm-reduction background developed and delivered activities

Flu Shot Clinics	• 2 immunization clinics through partnership with East End CHC • Targeted to higher-risk communities
Nutrition Workshops	• Culturally relevant information on nutrition • Hands-on demonstrations (cooking, label reading, etc.)
Nutrition/Dental Bingo	• Health promotion event at a respite site for homeless and street-involved individuals • Suitable for people with limited literacy skills and other barriers to accessing mainstream health-promotion resources
Mindful Art Workshop	• Art workshops to promote mental health • Chair yoga provides an exercise opportunity

GOALS

1. Design and deliver health promotion activities that build capacity to prevent health problems and avoid emergency-services usage over the long term
2. Create opportunities for collaboration with other community organizations to target activities to local needs

COSTS

Budget: $25,000

WHAT HAPPENED

Process

- Staff adapted general health-promotion advice to design hands-on demonstrations aimed at specific cultural groups and marginalized populations
- Staff devoted considerable time and effort to outreach and partnership building
- East End CHC provided flu immunization at 2 clinics arranged through the Health Boost initiative
- The Afghan Women's association provided space and translation for a series of 3 nutrition workshops facilitated by program staff; other activities were delivered by program staff at WWCC sites in Scarborough

Evaluation Activities

- Project leads were interviewed at the start and end of the intervention.
- Analysis of information on participant numbers and demographics was provided by WWCC and analysed by the evaluation team
- Project staff prepared a summary of activities delivered, including the results of surveys that were implemented for some activities. (Exit interviews with frontline staff had been planned, however they could not be conducted due to staffing changes related to the COVID-19 pandemic.)

Outputs

7 HEALTH PROMOTION EVENTS

49 INDIVIDUAL PARTICIPANTS

Program	Delivery	Participants
Flu Shot Clinics	• 1 at WWCC Teesdale satellite site • 1 at Oakridge Health and Harm Reduction Hub (basement of WWCC main site)	• 12 total flu shots • 7 of those immunized did not have OHIP cards
Nutrition Workshop	• 3 weekly workshops with the Afghan Women's Association	• 18 participants
Nutrition/Dental Bingo	• 1 event at the WWCC Respite Site • Vulnerable, high-needs clientele	• 7 participants
Mindful Art Workshop	• 1 event at the WWCC Kennedy site (2 planned events cancelled due to COVID-19)	• 12 participants (9 signed up for subsequent workshops that were cancelled)

FINDINGS

Perceived Impact

> "The communities we serve are very marginalized, and our clients are often in poverty. Our aim is to help use the resources that people do have to keep them going." – Project Lead

- The leads described the initiative as a means of testing a number of potential strategies to achieve long-term impacts in promoting health and reducing health problems among marginalized populations
    - Activities were described in terms of building community capacity to improve health and reduce emergency services utilization and preventable hospitalization over the long term; the program aimed to fill gaps by identifying potentially beneficial interventions that aren't ordinarily available to the communities targeted
    - Given the limited timeframe and number of participants, it is unlikely that the pilot programs had an immediate impact on utilization of other health services (e.g., emergency-department visits)
- Aside from the flu clinic, the leads see the Health Boost initiative as meeting needs that exist year-round
    - They perceive activities would achieve greater uptake and impact if they were available throughout the year
    - Furthermore, they perceive that consistent delivery of health-promotion activities could have indirect impacts on vaccination and other health choices: "If you give people information about healthy living, they'll get that the flu shot is important."
    - Having the program staffed year-round could allow for relationship building and replication of activities with different organizations
    - Furthermore, they perceive that consistent delivery of health-promotion activities could have indirect impacts on vaccination and other health choices
- Offering programs in the evening to mitigate the health impacts of social isolation was initially envisioned as a key activity, however logistical issues led the program to focus on other activities for the time-limited pilot; only 1 intervention (the art workshop) was delivered in the evening
- Outreach was more time-consuming and yielded less uptake from community organizations than anticipated
    - WWCC's experience has been that cultural organizations are the best means of reaching immigrant communities, especially newcomers

- While translations of the Canada Food guide and other health-promotion resources are available, the leads' experience suggests this is not sufficient to have an impact: hands-on interventions and in-person interactions are needed
- Many cultural communities in Scarborough have organizations with an engaged membership, however these organizations do not tend to have expertise in health promotion; the Health Boost initiative was intended to engage these organizations and deliver health-promotion sessions for their membership
- Some of the potential partner organizations are quite small, and staff found that follow-up was difficult
- Ultimately, only 1 such partnership led to program activities (the Nutrition Workshops)
- Lack of follow-up by partners that had initially expressed interest was seen as the main limitation to delivering more partnership-based activities

Timeframe & Implementation

- Plans to start in late 2019 were delayed when prospective staff withdrew during the hiring process and recruitment had to begin again, with a new program start-date in January
- Once the initiative was operational, staff simultaneously engaged in outreach, program design, and working towards implementation
  - This provided less lead-time than anticipated to conduct outreach and build partnerships, and delayed the planned start of the flu-shot clinics
- Activities were suspended by mid-March of 2020 due to the impact of COVID-19
  - Along with having to cancel 2 scheduled art workshops, program staff had aimed to organize further health-promotion workshops similar to the nutrition program and deliver before an extended Surge-pilot end-date in early April of 2020
  - Project staff began to work on internal processes for WWCC's pandemic response, however this work was re-assigned when Health Boost was suspended to enable the organization to focus on other priorities

> "We would have liked to continue into April and beyond. I feel like we would have hit the mark."
> – Project Lead

- WWCC intends to use learnings from this year's Surge-funded initiative in planning future health-promotion activities for marginalized populations; in particular, bringing partner-organizations on board at the planning stage was identified by the leads as crucial to ensuring programs are implemented smoothly

Activity-Specific Findings

Activity	Findings
Flu Clinics	*Feedback from Leads:* • Partnership with East End CHC was a successful means of ensuring vaccines could be delivered to people without OHIP cards • Start-date was too late to make a significant impact: staff reported that most potential participants had already received a flu shot at a primary care practice or another location
Mindful Art Workshops	*Feedback from Leads* • Along with the mental-health benefits of mindfulness and artistic expression, chair yoga and other aspects of the program are an opportunity for low-impact physical exercise • While client feedback was not formally elicited, the stated interest of 9 of 13 participants in attending future workshops, and the success of a similar ongoing program at the WWCC respite site, were seen as indications that the program is worth expanding ○ The leads would like to continue and expand the program with other resources once group activities can resume

Nutrition Workshops	*Feedback from Leads*
	• The partnership with the Afghan Women's Association was a successful means of reaching newcomers and imparting evidence-based nutrition information
	• Efforts to partner with other, less-established organizations were not as successful, however WWCC aims to continue working to engage with them through future initiatives
	Participant survey
	• A 'pop-quiz' was administered by staff after the workshops; clients achieved an average score of 82.3% on questions related to the content
	• 17 of the 18 participants provided feedback:
	  ○ 16 indicated they found the workshops helpful
	  ○ 15 indicated they would use the information to make or buy healthier foods

Nutrition/Dental Bingo	*Feedback from leads*
	• Successful means of engaging users of a respite site for homeless people in health-promotion activities related to nutrition and dental care
	• Given that clients of the respite site often have high levels of need related to nutrition and dental care, as well as few opportunities for structured activities, the event is seen as a potential model for future outreach at the respite site and amongst similar populations
	Participant survey
	• Of the 5 (of 7) participants who gave feedback
	  ○ 3 indicated they would use the information they received as part of their daily life
	  ○ 1 indicated they would use part of the information in their daily life

Project Outcomes

Expected Outcome	*How Did They Do?*
Design and deliver health promotion activities that build capacity to prevent health problems and avoid emergency-services usage over the long term	Successful in designing programs tailored for the target populations, which reached several dozen participants and are potentially scalable.
	Unable to evaluate prevention and emergency-services usage, as the impact of capacity-building is expected to occur over a longer term than the pilot period.
Create opportunities for collaboration with other community organizations to target activities to local needs	Moderately successful: collaboration with the 2 engaged partners led to delivery of planned activities, however efforts to engage a larger number of organizations did not come to fruition within the pilot period.

RECOMMENDATIONS

1. More planning, time, and resources would be needed for the Health Boost initiative to achieve its intended impact

   Aside from the flu clinic, the Health Boost initiative was aimed at needs that exist year-round, and interventions would need to be offered over a longer period to measure their effect (e.g., by tracking clients longitudinally).

   While engagement of cultural organizations is seen as the most effective means of reaching newcomers with health-promotion information, the Health Boost initiative demonstrated that sustained efforts are needed to lay the groundwork for these interventions.

2. Outreach and relationship-building with community organizations should begin prior to the design of interventions

   Ensuring potential partner-organizations are committed to facilitating the programs designed for the intervention could broaden their reach.

   More time for outreach and scheduling could help address social isolation by delivering programs in the evening.

3. Along with starting earlier, flu clinics should be targeted more specifically to populations that are least likely to be immunized

   While this year's clinic did start late in the flu season, the fact that many potential recipients indicated they had already been immunized – sometimes through conventional primary care arrangements – suggests there may not have been a high level of unmet need among people at the particular sites targeted. Efforts to identify and reach individuals or sub-communities who don't receive a vaccine at any time during flu season might have a greater impact.

4. More robust evaluation of pilot initiatives could lead to a more reliable assessment of their impact and provide insights into how they might be scaled-up or further adjusted address local needs

LEARNINGS

Beyond the individual project assessments, several cross-cutting themes emerged during the evaluation. These represent common learnings for the winter surge initiative as a whole. The main thematic learnings are summarized below:

Theme 1: Projects with specific, achievable goals performed better

- Projects with specific objectives were able to proceed from proposal to implementation more smoothly than projects with vague goals
- Proposals often specified goals that could not be realistically achieved within the funding period; ensuring proposed activities are feasible would reduce delays in project launch

Notes:

- Incomplete or vague proposals can delay initiatives and lead to missed opportunities for collaboration
- Proposals were well-aligned with Surge funding objectives but often specified goals that could not be realistically achieved within the funding period
- Ensuring proposed activities are feasible could avoid delays in project launch and create opportunities for collaboration and integration

Theme 2: Rescoping of projects needs to be done carefully

- A number of projects changed substantially between the proposal stage and implementation
- While it may make sense to rescope a project in certain circumstances, this should be done purposefully as additional time will be needed to make adjustments, impacting the start date
- A clear process is needed for engaging all stakeholders (e.g., funders, executive sponsors, project leads, front-line staff) when a decision is made to rescope a project

Notes:

- Funding for primary-care initiatives was redirected to entirely new projects
- Some projects made deliberate adjustments to their interventions in response to challenges and opportunities
- Engagement of executives and project management are essential to making effective decisions about when to proceed with plans and when to adjust based on opportunities for improvement

Theme 3: Missed opportunities for integration and partnership between projects

- Multiple projects had similar activities that could have benefited from coordination and integration
- While some groups were encouraged to work together, this did not end up happening
- Establishing mechanisms to support partners in collaborating could lead to integrated projects that have greater impact and better meet community needs

Notes:

- There were multiple instances of projects with similar activities running independent of each other (e.g., NICE funds, flu clinics, and hospital-based transportation projects)
- Coordination and integration of similar projects would likely result in better overall effectiveness
- Encouraging partners to collaborate could help meet needs more systematically and broaden impact

Theme 4: Project management is a key success factor

- Projects that had a designated project manager tended to run smoother, be more strategic, and have activities that were aligned with the project's stated goals
- However, many projects did not have a designated project manager, including those projects that experienced the most problems in terms of design and implementation
- Project management is crucial to ensuring individual projects run smoothly
- A dedicated project manager would also benefit the overall Surge initiative

Notes:

- Project management is crucial to ensuring implementation proceeds smoothly and challenges are identified and addressed pro-actively
- A dedicated project manager for the overall Surge initiative could support partners in developing proposals and implementation plans, provide support for projects that do not have capacity for project management, and ensure accountability of projects to the funders

Theme 5: Few projects took advantage of the opportunity to learn from evaluation

- Many of the project leads were unclear on the purpose of the evaluation, who was carrying out the evaluation, or how the evaluation was meant to be used as a learning opportunity
- Projects that did engage with the evaluation team early on were able to deliver reliable and targeted data and provide more substantive feedback
- To maximize learning, projects should collect metrics that are specifically geared to evaluating the project's goals and anticipated outcomes
- Clear expectations need to be conveyed from funders and executive sponsors to project leads regarding their responsibilities in terms of data collection and evaluation

Notes:

- While some projects responded to offers of support from the evaluation team, most did not
- In several projects, there were serious issues with data reliability and a lack of information about the program intervention, which greatly limited the potential for learning
- Despite repeated efforts to connect to project leads, some did not talk with the evaluation team after the intervention had ended
- Given the issues with responsiveness, concrete steps are needed to ensure projects follow-up with the evaluation team in a timely manner so that the potential for learning is fully realized

RECOMMENDATIONS

The following recommendations build on the Learnings in the previous section and relate to three crucial dimensions of program development and delivery.

Design

More attention is needed at the proposal stage for both projects and funders.

Encourage projects to be narrow and specific in their aims

- Projects with specific aims tended to perform better

MGH should hire a project manager to specifically oversee Surge initiatives

- A well-qualified project manager to oversee the Surge initiatives could support partners in developing and implementing interventions, as well as serve as a central point of contact and accountability

Encourage partnership/integration between similar projects

- Collaboration could help meet needs more systematically and broaden the impact of projects

Implementation

Careful attention to implementation is needed for projects to run smoothly and have the greatest impact.

Pro-actively address discrepancies between proposal and implementation plans

- This will help prevent project drift and scope creep

Projects should hire a project manager, if possible.

- At a minimum, projects should clearly identify a project lead who will be responsible for ensuring smooth implementation

Ensure leadership are committed and engaged

- Oversight by organization leaders is crucial to ensuring successful implementation

Evaluation

More effort is needed to support meaningful evaluation.

Clearly communicate expectations around evaluation to project leads and sponsors

- Not all projects understood the purpose of evaluation and most projects did not take advantage of the evaluation as a learning opportunity

Identify project-specific metrics for all projects

- This will enable meaningful evaluation and improvement over time

Require project leads to make early and frequent contact with the evaluation team

- Early and frequent contact allows for quick identification and solving of potential problems

Thank you for reading this report.

For further information about the evaluation,
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