RAPID HEPATITIS C POINT-OF-CARE RNA TESTING & TREATMENT

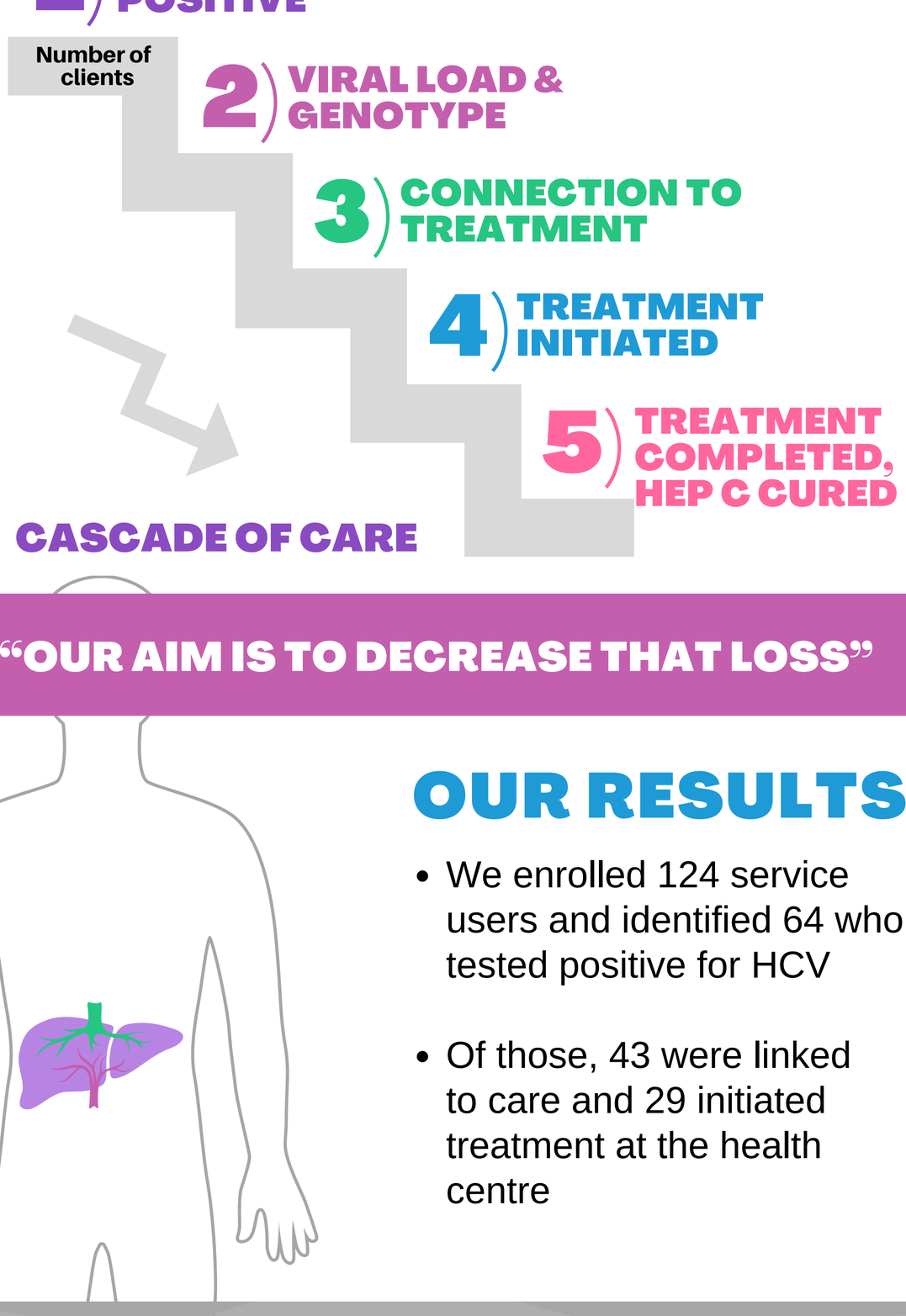
East Toronto Health Partners

THE ISSUE

Hepatitis C (HCV) is one of the most common chronic viral infections, with an estimated 58 million people living with Hepatitis C worldwide. Although most new cases of HCV in Canada occur among people who use drugs, treatment in this group remains low. Significant barriers to HCV care exist at the individual and system level, starting with access to testing and following along the cascade of care through to cure.

OUR GOAL

Provide a new form of Hepatitis C testing using the Cepheid GeneXpert platform. This testing measures Hepatitis C virus in the blood using only a drop from a finger prick. Instead of two tests – an antibody test followed by a viral load test – the GeneXpert gives a viral load result in one hour. Testing was offered every three months for a year. People who had a positive viral load result were invited to connect with the Toronto Community Hep C Program for treatment.



THE HCV RNA TEST OFFERS RESULTS WITHIN 1HR

WHAT WE DID

Beginning in August 2018, South Riverdale Community Health Centre (SRCHC) in partnership with Michael Garron Hospital began offering rapid POC Cepheid Genexpert HCV testing within the SRCHC's supervised consumption site (safe injection sites) two-and-a-half days per week. Cepheid Genexpert uses a finger stick to identify a viral load and determine if someone has HCV.

Participants who tested positive for HCV RNA were immediately connected with an onsite HCV treatment program. The treatment nurse completed baseline surveys with participants to capture socio-demographic data and history of HCV care. As visitors to supervised consumption sites tend to return, staff also provided ongoing post-testing counselling when required. Visitors who tested HCV RNA negative at baseline were offered repeat testing every three months for up to four visits.

OUR RESULTS

- We enrolled 124 service users and identified 64 who tested positive for HCV
- Of those, 43 were linked to care and 29 initiated treatment at the health centre

LESSONS LEARNED

This model of low-barrier testing and co-location of treatment services had high interest and engagement among people who inject drugs. The development of client-centered, low barrier, integrated care models is necessary to continue to meet the needs of communities marginalized by society.

Project Team:

Bernadette Lettner, Project Lead, Hepatitis C Treatment Nurse & Kate Mason, Research Coordinator, South Riverdale Community Health Centre; Jeff Powis, Michael Garron Hospital

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

South Riverdale COMMUNITY HEALTH CENTRE

DYSPHAGIA SCREENING, ASSESSMENT, AND MANAGEMENT - A SURVEY

East Toronto Health Partners

WHAT IS DYSPHAGIA?

Dysphagia is the medical term for **swallowing difficulties**.

WHAT IS ASPIRATION?

Aspiration refers to material (e.g., food, liquid, or saliva) entering the airway and potentially into the lungs. It occurs when the airway is not properly closed/protected during the swallow and “things go the wrong way”.

SYMPTOMS OF DYSPHAGIA

THE ISSUE WE EXPLORED

Many healthcare professionals are involved in the screening, assessment and management of people with dysphagia, including Speech-Language Pathologists (S-LPs), Nurses, PSWs, Registered Dietitians, and others.

When aspiration of thin fluids (e.g., water, broth, milk) is a risk, a common practice is to make the fluids thicker. However, sometimes ice chips are also given, but when and how much seems to differ between healthcare settings and professionals. There is also little research evidence to show that people who aspirate thin fluids may also aspirate ice chips, so the rationale for when a person is “allowed to have” thin fluids vs. ice chips is not very clear.

Our survey of health practitioners across southern and central Ontario aimed to compare the use of ice chips in dysphagia screening, assessment, and management across healthcare settings and professional disciplines. The survey results (still being finalized) may demonstrate knowledge gaps and spark future clinical research as well as the development of best practice guidelines.

PRELIMINARY FINDINGS INCLUDE:

- Clinicians do not necessarily include ice chips in their swallowing screening or assessments, yet frequently suggest ice chips as part of dysphagia management (e.g., diet and/or therapy plan)
- Comfort/pleasure and feeding despite aspiration risks were reported as the most common purpose for giving or recommending ice chips across all healthcare settings
- Institutional barriers such as availability of ice chips, lack of standardized protocol, and the need for supervision/education were reported as reasons for not recommending or giving ice chips
- Respondents highlighted the importance of conducting thorough oral care prior to offering ice chips, and ice chips may in turn alleviate dry mouth and contribute to improved oral hygiene

MORE THAN 100 SURVEY RESPONSES INFORMED OUR FINDINGS

Tin Yan Chan
Speech-Language Pathologist,
Michael Garron Hospital

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

COMMUNITY SURGE EVALUATIONS: USING A LEARNING HEALTH SYSTEM APPROACH TO EVALUATE AN INTEGRATED PARTNERSHIP IN EAST TORONTO

East Toronto Health Partners

OUR GOAL

To create and embed rapid cycles of evaluation to support learning, knowledge transfer and decision-making in order to scale and spread our new model of integrated care and create a learning health system within the East Toronto Health Partners (ETHP) OHT.

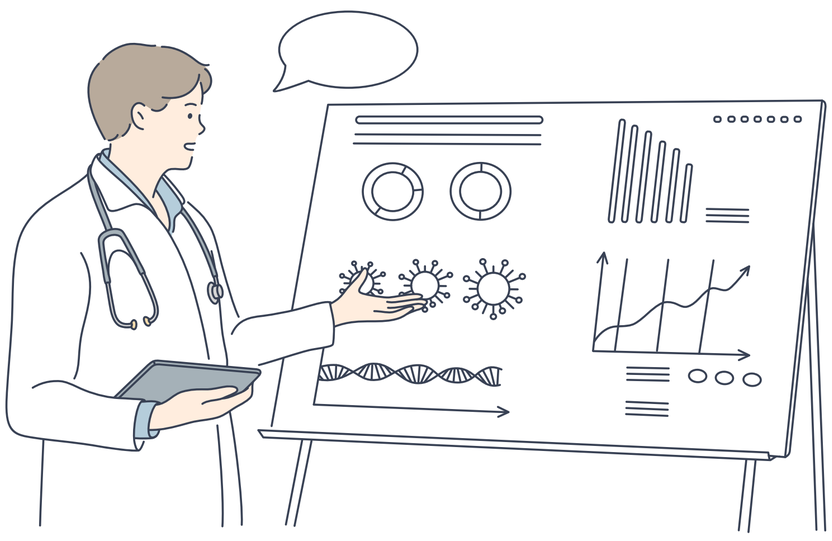
BUILDING AN EVALUATION MINDSET AND CAPACITY

The evaluation journey started in 2018 with an external evaluation led by scientists affiliated with the University of Toronto. Based on their findings, it was decided to switch from an external evaluation to an internal evaluation with an aim of building internal evaluation capacity. ETHP chose the Community Surge Initiative to evaluate and test ideas, learn from them, and make changes at the system level. A steering committee that included patients and caregivers oversaw the work.

One of the needs identified was establishing internal evaluation capacity within ETHP organizations. In 2020/21, we held workshops on the basics of evaluations. In 2021/22, the focus was on choosing smart measures and data collection. Next, we will focus on qualitative and quantitative analysis. Additionally, we have co-designed evaluation templates for partners to use including:

- a simplified logic model template
- a template of evaluation questions, and
- a measurement table template (i.e. project managers who implement and evaluatie surge initiatives).

We are now scaling and spreading this work and have evaluated more than 20 projects since 2020 through our health system community of practice.



> **People need to understand that evaluation is an opportunity to improve and learn. There is no failure. Everything we do is a prototype for the next improvement.**

HOW OUR LEARNING CAN HELP OTHERS

Partners can adapt our framework, templates and evaluation approach for internal use. There is also a chance to learn from our different approaches to evaluation (beyond surveys) for small-scale projects. We are also available to provide consultation for the creation and execution of evaluation plans.

We have also found that for evaluations to lead to learning and improvement, more resources are needed. Evaluation often involves more effort than people estimate, such as designing an effective survey (e.g. choosing measures that will garner meaningful and not just complimentary results) or identifying an appropriate survey to meet your needs, determining how and to whom it will be distributed, collecting the data and analyzing the data.

Project Team:

Dr. Sara Shearkhani, CIHR Health system Impact Postdoctoral Fellow, ETHP,
Mark Fam, Dr. Anne Wojtak, Dr. Walter Wodchis

HSPN

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

CAREGIVER SUPPORT INITIATIVE & NICE FUND

East Toronto Health Partners

OUR GOAL

Through work with a Caregiver Advisory Group, Woodgreen identified a need to support caregivers, particularly those from diverse ethnocultural communities, to access resources they need, then collaborated to:

1. Enhance engagement of caregivers
2. Improve caregiver experience of access and navigation of services by way of Caregiver NICE Fund

WHAT WE DID

For the **Caregiver Support Initiative**, Woodgreen co-designed resources with members of the Caregiver Advisory Group to raise caregiver awareness of services available during the winter months (surge period). The co-design project team held several sessions to:

Identify the barriers caregivers experience trying to find information on available services

Identify sources of information that caregivers most frequently use

Identify sources that address barriers (e.g. language, 24/7 access,)

Develop tools to promote the information

The Caregiver Support promotional campaign ran for five weeks:

- Leveraging Woodgreen's Diverse Caregiver Access Project (DCAP), resources were gathered, created and translated into six languages commonly spoken in East Toronto.
- Resources were promoted in the community with the help of the Community Ambassadors, TTC posters in 5-6 subway stations in East Toronto and OMNI ads in 5 different languages.
- The Toronto Seniors Helpline website was updated with new resources in each of the six languages.

The ETHP created the **NICE Fund** to provide supports for seniors who cannot access any other services. Two co-design sessions with members of the Caregiver Advisory Group were held to review the NICE Fund eligibility criteria and application form and streamline the fund access processes.

- We received 79 applications over 11 weeks and 61 caregivers received funding.
- Average funding approved per application was $850.

WHAT WE LEARNED

MEANINGFUL ENGAGEMENT WORKS | The project involved caregivers in every step of the process—from developing the project proposal to evaluation. Their input helped us prioritize how resources were spent and focus on the most relevant products, services, promotional channels and languages to reach the most caregivers from diverse communities.

EFFECTIVE CROSS-PROJECT COLLABORATION | We successfully collaborated with other projects (e.g. DCAP) and organizations (nine partner organizations submitted NICE Fund applications and the Neighbourhood Organization's community ambassadors helped distribute resources).

Project Team:

Kendelle Labella, Project Manager & Geriatric Case Manager, Woodgreen Community Services; Nena Pendevska, Project Manager, Ontario Health Team Initiatives and East Toronto Health Partners Engagement

WOODGREEN

Opportunity made here.

ETHP COLLABORATIVE QUALITY IMPROVEMENT PLAN: ALTERNATE LEVEL OF CARE

East Toronto Health Partners

OUR GOAL

As we work to recover from COVID, it's more important than ever that we support patient transitions to access care in the most appropriate setting, ensuring hospital beds are available for those with acute care needs. A patient is designated "alternate level of care" (ALC) when they are occupying a bed in hospital and do not require the intensity of resources or services provided in this care setting. A designation of ALC can have negative effects on the patient, as well as stress and uncertainty for family caregivers. In 2021, partners in East Toronto came together to prioritize areas of work to better support seniors and caregivers to prevent unnecessary hospitalizations and avoid delayed discharges.

OUR QUALITY IMPROVEMENT PLAN

In our 2022-23 Collaborative Quality Improvement Plan for ALC, we have outlined three areas of work:

1. **Identify at-risk seniors and caregivers as early and as proactively as possible and connect them to services and supports offered by ETHP member organizations.**

2. **Strengthen patient navigation, caregiver supports, and service outreach with a focus on our priority neighbourhoods.**

3. **Expand partnerships between hospital and community to ensure rapid access to home care, transitional care, and community services where appropriate.**

PROGRESS

We have worked to understand population-level data for East Toronto Health Partners' attributed population and to identify areas for collective improvement in our work as an integrated system of care. Our QI work as an OHT is just getting started.

PARTNERING TO MANAGE ALC

In April 2020, Michael Garron Hospital (MGH) partnered with VHA Home HealthCare to develop the Kew Beach Unit, which created 20 additional acute care beds in response to COVID-19. The program expanded incrementally over the next 18 months to house 72 beds. Designated a hospital unit with patients transferred from MGH, the care model included RNs, RPNs, PSWs, Sitters, PT, OT, PTAs, Environmental Services, Consulting S-LP, foot care, wound care and a dietician. The Kew Beach Unit accepts transfers that are more complex than typically discharged to transitional care units.

Project Team:

Rishma Pradhan, Senior Project Manager, East Toronto Health Partners & East Toronto Family Practice Network; Margery Konan, Senior Project Manager, East Toronto Health Partners

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

VHA Home HealthCare
Creating More Independence

PRIMARY AND COMMUNITY CARE (PCC) RESPONSE TEAMS

East Toronto Health Partners

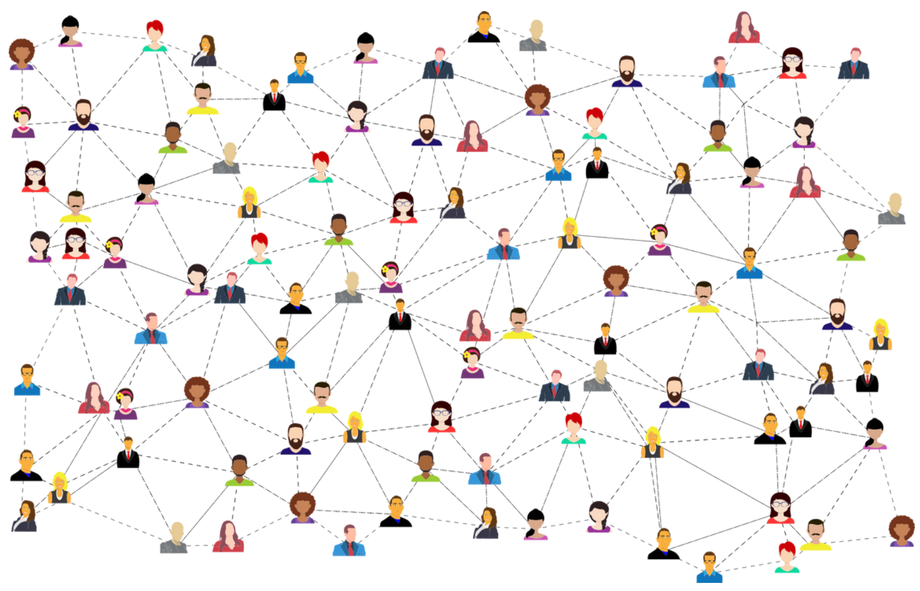
ABOUT PCC RESPONSE TEAMS

PCC Response Teams is an integrated care planning program of East Toronto Health Partners (ETHP) that provides localized, team-based health and social services care planning support. This support is focused on system navigation and service connection for vulnerable adults living in east Toronto. There are four PCC Response Teams—each supports clients living within different East Toronto neighbourhoods. These interdisciplinary teams, which regularly come together virtually, are comprised of health and social services providers and in some cases volunteer community health ambassadors.

WHAT WE SET OUT TO DO

To improve health outcomes by addressing social determinants of health and supporting an integrated system of care across our East Toronto communities by:

- Improving access to integrated care
- Enhancing partnerships and integrations
- Improving provider experience
- Improving client and caregiver experience
- Improving psychosocial and physical health outcomes for clients



PROJECT ACTIVITIES

To support the PCC Response Teams program we have:

1. Created a centralized, accessible document sharing system
2. Created project charter to direct program planning, delivery and evaluation.
3. Developed a governance structure to support the program, which includes cross-organizational and cross-sector planning groups, such as a steering committee to direct the work and workgroups to support operations, engagement and evaluation. Each committee and workgroup developed terms of reference and aligned work plans to support their work.
4. Created four distinct, currently operating, interdisciplinary, cross-organizational, cross-sector Primary and Community Care Response Teams that support care planning for clients living within the East Toronto neighbourhoods that they serve.
5. Developed the Senior Mental Health Collaborative, a model for integrating geriatric psychiatry and behaviour support specialist consultation
6. Supported capacity building of providers by organizing a two-part education series on working with clients with complex personalities
7. Developed tools and processes to support operations including:
   a. Digital system to support cross-organization, cross-sector operations and accountability which included centralized referral and care planning tools and processes.
   b. Standardized operational processes, onboarding tools/process for new members, and partner/member tracking
8. Developed tools and processes to support engagement including:
   a. Community engagement framework that resulted in the inclusion of six community advisors on key planning groups
   b. Program webpage on ETHP website
   c. Outreach materials (e.g. flyer, presentations)
9. Developed tools and processes to support evaluation including:
   a. Logic model and measurement plan
   b. Annual member/provider survey
   c. Data analysis frameworks, tools and processes
   d. Standard quarterly reports

Lori Sutton
Project Facilitator, South Riverdale Community Health Centre

South Riverdale COMMUNITY HEALTH CENTRE

A LOCAL SYSTEM RESPONSE TO COVID-19 PANDEMIC

East Toronto Health Partners

OUR GOAL

East Toronto Health Partners (ETHP)—a team of 50+ health and social organizations—is implementing a new model of integrated care (IC) and the stakeholders of ETHP have been collaborating to respond to the COVID-19 pandemic since March 2020. We evaluated ETHP's collective response to the pandemic from a partners-and-staff perspective.

WHAT WE DID

We interviewed 30 key informants, who have been identified as playing critical roles in the East Toronto COVID-19 response across acute care, home care, community care, and long-term care. The semi-structured interviews were designed to learn about the ETHP COVID-19 strategy, the impact of the response, and lessons learned for advancing a new model of IC in East Toronto.

We have completed this evaluation and are now sharing the results for feedback with key stakeholders.

KEY FINDINGS

Participants identified missed opportunities, including advocacy for broader health care reforms; better (re)allocation of resources for mental health needs and food security, and fully catalyzing our relationship with government agencies.

The main implications are to continue using the structures built during COVID-19 to support infectious disease response and chronic disease management as well as a greater focus on population health and integration of health and social care services.

ETHP'S COVID RESPONSE

Project Team:

Dr. Sara Shearkhani, CIHR Health System Impact Postdoctoral Fellow, ETHP; Dr. Anne Wojtak, Michael Garron Hospital

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

MARCO COVID-19 ISOLATION AND RECOVERY SITES (CIRS) EVALUATION

East Toronto Health Partners

PROJECT BACKGROUND AND GOALS

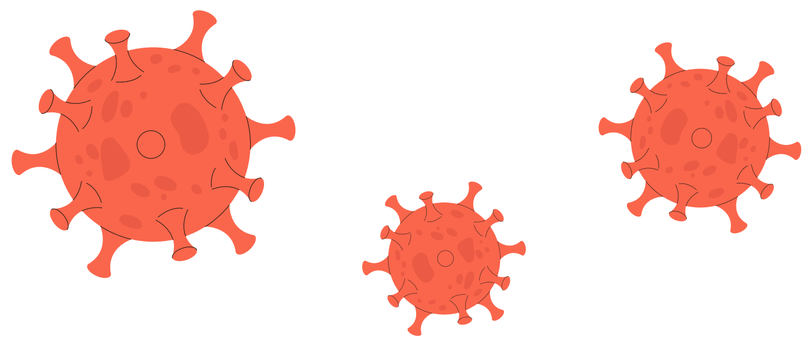
This project is part of the MARCO Study which focused on people experiencing marginalization and the effects of the COVD-19 pandemic response. During the pandemic, the City of Toronto, in partnership with several organizations, opened three COVID-19 Isolation and Recovery Sites (CIRS) in response to the need for supported isolation spaces for people experiencing homelessness. Our research aimed to identify lessons learned and understand how the CIRS model was developed, its defining characteristics in terms of structures, services and decision making, and how the model influenced staff and client experiences.

WHAT WE DID

As a team of academic and community researchers, we conducted an evaluation of the CIRS which included a logic model to guide our evaluation.

We then used qualitative research methods to evaluate the CIRS, focusing on decision-making and the structure of the models. Between January and June 2021, we conducted 43 qualitative key informant interviews with individuals from these five groups:

- Nurses and Physicians
- Peers and Harm Reduction workers
- Executive Leads
- Operational leads
- Funders and Decision Makers



We coded the interviews and looked for key ideas around how the CIRS were developed, their day-to-day operations, and how they functioned within a larger system of health and social services in Toronto.

Our key findings have been published in a brief and full report at: **https://maphealth.ca/marco/**

WHAT WE LEARNED

- CIRS can serve as a case study for greater integration of services across partner organizations for people experiencing homelessness
- The success of an integrated model will require careful attention to power imbalances and hierarchies and will require partner organizations to participate fully in decision making
- Lessons from the CIRS offer an important opportunity to rethink shelter settings
- Read our 7 Key Recommendations in the full report

WHAT'S NEXT

- Knowledge transfer of evaluation findings and recommendations to other OHT groups and crosfunctional COVID-19 response groups
- Publication in scientific journals
- Funding has been received for a second phase of research, MARCO:POLO, which will look at intersectionality and system-level impacts across the full MARCO study.

Project Leads:

Ahmed Bayoumi & Michelle Firestone, Research Scientists, MAP Centre for Urban Health Solutions, Unity Health Toronto; Lorie Steer, VP, Urban Health and Homelessness Services, The Neighbourhood Group

UNITY HEALTH TORONTO

Funded by: University of Toronto COVID-19 Action Initiative, University of Toronto Faculty of Medicine Equity, Diversity and Inclusion Fund and the St. Micheal's Hospital Foundation.

COMPREHENSIVE CARE AND INTEGRATION SPECIALIST (CCIS) TEAM

East Toronto Health Partners

THE ISSUE

Clients with complex needs are returning to hospital post-discharge because they experience challenges with accessing needed services and supports to enable their at-home recovery.

WHAT WE DO

CCIS Team exists to fill gaps in care and to support smooth service transitions for individuals living with complex health and psychosocial issues. Our priority population is frail seniors and individuals living with mental health and/or addictions issues and psychogeriatric concerns who may have few personal supports and are not well connected to the healthcare system. The CCIS Team of specialists from three agencies connects clients to essential services and supports so that they can reach their goals and thrive upon release from hospital.

200 REFERRALS SINCE JANUARY 2021

Our specialists provide short term, intensive support and care coordination and typically spend three months with the client to build trust and ensure the client has the supports they need during the transition phase.

AN EFFECTIVE RESPONSE

- **Complex clients are being served** – Complex clients are few in number but are top-tier users of the healthcare system. The CCIS Team approach effectively addresses their needs and reduces their impact on the system.
- **High needs are addressed** – Mental health and addictions and psychogeriatric care are greatly needed in East Toronto and these are addressed through the team's collaborations with partners.
- **Strengthening service relationships and effectiveness** – Working with Michael Garron Hospital and community agencies, the CCIS Team identifies gaps when the referral is submitted and works with the client and their care team (if there is one) to sustain what they have or make it better.
- **Primary care attachment** – The team (re)connects the client to a primary care provider.
- **Coordinated Care Plan development** – In collaboration with the client, we identify goals and the underlying needs to reach those goals (e.g. client goal is housing but the need is supportive housing and home care support)

Project Team:

Irina Sytcheva, Director: Mental Health, Addictions, and Developmental Services, Stephanie Gordon, Supervisor, CCIS, and Rochelle McAlister, Senior Manager, Seniors' Mental Health & Addictions, WoodGreen Community Services; Martha Northey, Director, Cota; Robin Griller, Executive Director, St. Michael's Homes

Michael Garron Hospital – Toronto East Health Network
WoodGreen – Opportunity made here.
St. Michael's Homes
Cota – Inspiring Change

EAST EFFORT: HIGH-PRIORITY COMMUNITIES COVID-19 RESPONSE INITIATIVE

East Toronto Health Partners

OUR GOAL

Funding for the High-Priority Communities (HPC) initiative was tied to three strategy pillars:

- Community Outreach and Education – Increase awareness of COVID-19 and reduce transmission
- Access to Testing – Increase testing in HPCs
- Wraparound Supports – Remove barriers to COVID-19 prevention, including isolation and vaccination

WHAT WE DID

In the three phases since launching in 2020, we invited agencies and community-based, grassroots groups to submit funding proposals. The Steering Committee aimed for a balance of programs that ensured distribution throughout the priority communities and that all goals and priorities were addressed. The programs delivered have included:

- Community-Based Programs
- Community Health Ambassadors
- Individual and Family Support Fund
- Grocery Gift Card Program
- Distribution of Personal Protective Equipment (PPE) and Rapid Antigen Tests (RATs)

To date, East Effort has accomplished the following:

- Served over 97,400 individuals, including providing case management to over 4,900 clients
- Worked with over 370 partners
- Recruited over 1,340 Community Health Ambassadors (CHAs) to engage in COVID prevention and education including vaccination
- Distributed over 44,300 PPE kits and over 58,300 RATs with a focus on equity deserving groups

BY COMMUNITY, FOR COMMUNITY

Community Health Ambassadors (CHA) are pillars of our projects. Throughout the pandemic, CHAs have been providing extensive support with language-specific and culturally-relevant COVID-related education to their communities, as well as PPE distribution, sharing knowledge and supporting community members to access other available supports.

Our **support program and grocery gift card program** has allowed us to learn more about the social determinants of health and wellness. Reaching more than 2,550 clients, the program and funding grassroots community initiatives that perform mutual aid in HPCs, it has also helped us connect community members to resources for housing, mental health, food insecurity and senior support.

Another important early challenge was the **balance between urgency and thoughtful delivery of services**. This initiative had immediate pressures and needs to address, however, we felt it was important that community consultation and needs assessment take place and some functional tools be set up to function optimally.

East Effort Lead Agency Project Team:

Hamna Mughal, Elissa Hermolin & Jen Quinlan

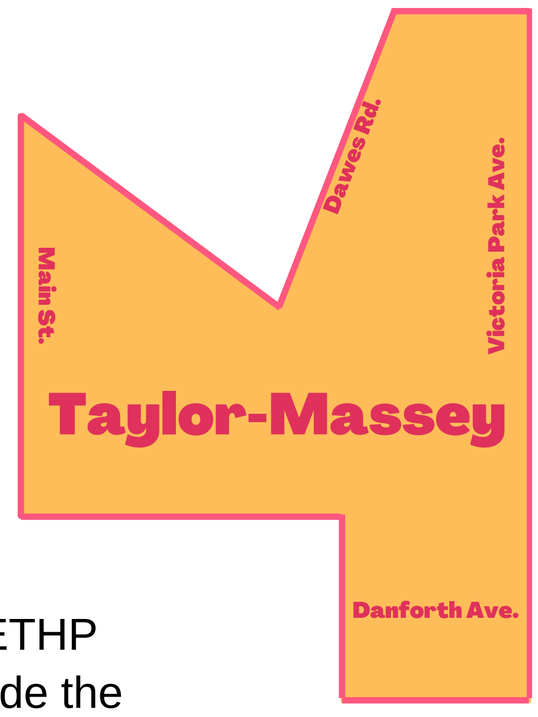
fhc FLEMINGDON HEALTH CENTRE

HEALTH ACCESS TAYLOR MASSEY (HATM)

East Toronto Health Partners

THE CHALLENGE

The Taylor Massey neighbourhood is severely underserved when it comes to local health services due to high demand and an exodus of physicians from the area. The ETHP and community members from the Taylor Massey Residents Wellness Council determined that a coordinated multi-sectoral approach is required to provide the range of services needed in the area, such as primary care, settlement, health education and financial empowerment programs.



OUR GOALS

Under the leadership of the East Toronto Family Practice Network (EasT-FPN), the ETHP has established Health Access Taylor Massey (HATM). The goal of HATM is to provide the neighbourhood with new primary care and interprofessional resources while leveraging existing supports and services in the community to improve access to services. HATM aims to address locally identified needs and priorities for health and wellness through a range of services.

Anyone can use the services of the HATM. They don't have to be connected to the primary care team. An onsite care navigator can help them coordinate the services offered.

> **The community in this neighbourhood is extremely engaged, motivated and active in identify their needs and doing the work to push things forward.**

EARLY STAGE ACCOMPLISHMENTS

This project is still in the early stages, but with many partners we are applying a team-based approach to support greater primary care and expand services. Collectively, we:

- Have connected with primary care physicians operating in the area
- Identified a clinic space in Crescent Town and negotiated taking it on
- Renovated and equipped the HATM clinic space—preserving it for primary care while adding more services to meet community needs
- Are developing connections to offer as many services onsite as space supports or create pathways for clients to access broader services
- With Michael Garron's support, are offering the Taylor Massey COVID Outreach Centre – testing, vaccination and full assessment and are now integrating mental health supports into the clinic
- Are in the process of integrating the EasT-FPN IPC Teams into a single HATM IPC Team and developing the HATM Evaluation Plan.

NEXT STEPS

In the near term, we hope to offer primary and interprofessional care onsite in the clinic space in Crescent Town and add cancer screening and immunization catchup services while developing the administrative and technology infrastructure (e.g. cross-service EMR) to support the work. Mid-term, we'd like to add metabolic clinic catchup services(e.g. diabetes, hypertension). We continue to engage with the Taylor Massey Residents Wellness Council—a highly engaged group that identified the need for primary care then a hub—to ensure this space meets community needs.

Farin Ghaemi
Project Manager,
Michael Garron Hospital

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

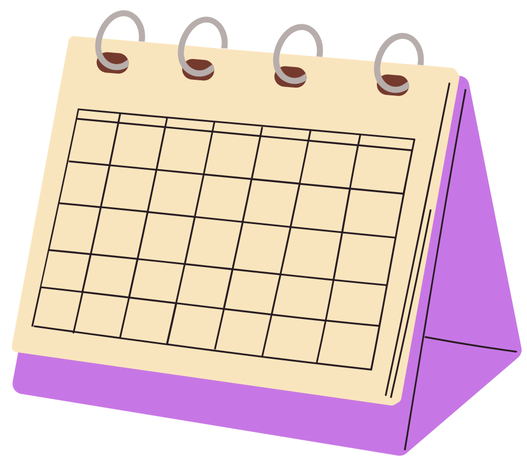
ESSENTIAL CARE ON WEEKENDS (ECoW)

East Toronto Health Partners

THE CHALLENGE

With limited available personal support worker (PSW) capacity, how can we revise current practices for weekend PSW scheduling to increase the number of clients—particularly complex clients—that VHA Home HealthCare can serve? Essentially, 'how might we be more nimble to provide clients with the essential care they need while keeping our staff happy, supported, and fully working?'

OUR SOLUTION



VHA Home HealthCare conducted a rigorous engagement program involving point of care providers,supervisors, managers and scheduling coordinators, facilitated by an innovation specialist to brainstorm and identify a promising approach to address ongoing weekend capacity challenges. These consultations led to

- an action plan
- process mapping
- an implementation plan that included both operational and evaluation metrics

ECoW was implemented and evaluated as a pilot program in the Toronto Central (TC) region among the 10 TC Teams from February to August 2021. The activities and operations included:

Prioritize more complex and vulnerable clients during weekends when PSW capacity is limited

- Shift PSW care client schedules so those who do not require 6 or 7 days of service are scheduled on weekdays when PSW capacity is higher.
- Shift weekend PSW service focus to essential care or only what is necessary for the safety of each client.

Improve Care and Travel Efficiency

- Adjust PSW schedules so that care and travel between clients could be completed within one hour during peak times. PSWs were assigned clients within smaller geographical areas where travel time is minimized to 15 minutes or less.

WHAT WE LEARNED

The scheduling principles of Essential Care on Weekends remain in place at VHA and sustainability strategies have been applied. We analyzed the data collected during the pilot implementation period and evaluated it along three key metrics: continuity of care, access to care and, experience: The data shows many promising results, including:

- 55% decrease in missed care on weekends (continuity)
- an increase in referral acceptance rates by 21% (access)
- stable experience for providers working on weekends and decreased unpaid travel time (experience)

Based on these key outcomes, there is potential for revised scheduling practices to positively impact the continuity and access to care that other community-based agencies are able to provide. With the demand for PSW services currently outgrowing available capacity, it is crucial to create innovative practices that increase PSW capacity and mitigate strain on the health care system.

Project Team:

Margery Konan, Senior Project Manager, Ontario Health Team Partnerships & Network Development, Michael Garron Hospital & VHA Home HealthCare; Sandra Tedesco, Regional Director, Toronto Central Region, Kristyna Drabinova, CSC Operations Supervisor and Sandra MacKay, Vice President, Research & Innovation at VHA Home HealthCare

VHA Home HealthCare

Creating More Independence

10 MIN. TRAINING E-MODULE ON OCCUPATIONAL HAND DERMATITIS

East Toronto Health Partners

WHAT IS OCCUPATIONAL HAND DERMATITIS?

Occupational hand dermatitis is an important health concern for healthcare workers who are often involved in wet work (e.g., washing hands, wearing gloves, etc.), yet a previous report by Public Health Ontario (PHO) identified a lack of training materials on this topic. This study aimed to fill that gap.

PROJECT GOALS

- Develop a training e-module on occupational hand dermatitis designed for healthcare workers with input from a multi-stakeholder group.
- Assess usability of the training e-module.
- Evaluate whether the training improved knowledge about occupational hand dermatitis.

HOW WE DID IT

1. Gathered input through multiple stakeholder meetings that included Centre for Research Expertise in Occupational Disease (CREOD), Ontario Occupational Health Nurses Association (OOHNA), Ontario Public Service Employees Union (OPSEU), Public Health Ontario (PHO), Public Services Health & Safety Association (PSHSA), and VHA Home HealthCare.
2. Collaboratively created the training content, design the training e-module, test the training, and finalize the e-module with the multi-stakeholder expert advisory committee
3. Developed a knowledge test to evaluate the training. Participants completed the test before and immediately after completing the training and again six months post-training.
4. Administered a usability survey post-training.

WHAT WE LEARNED

Evaluation findings suggest that healthcare workers improved their knowledge about occupational hand dermatitis after the training and retained higher knowledge at the six-month follow-up. The majority of participants rated the e-module training to be highly useable and would recommend it to a colleague.

TAKE THE TRAINING

You can find the occupational hand dermatitis e-module here:
English - https://creod.on.ca/SkinDiseasePreventionEN/story.html
French - https://creod.on.ca/SkinDiseasePreventionFR/story.html

wsib ONTARIO

THIS PROJECT WAS FUNDED BY THE WSIB

Project Team:

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creod Centre for Research Expertise in Occupational Disease

VHA Home HealthCare
Creating More Independence

REFILL YOUR CUP:
AN EMOTIONAL SUPPORT RESOURCE DIRECTORY

East Toronto Health Partners

OBJECTIVES

1. Understand home care providers' perspectives on their emotional support needs, current and preferred sources of support, and barriers to accessing resources.
2. Provide informational resources to facilitate and encourage access to emotional support.

OUR SURVEY

VHA's research team worked with a provider advisory group of two PSWs, one nurse and a rehabilitation services provider to create and administer a web-based survey of home care providers. The survey gathered perspectives on emotional support needs, current and preferred sources of support, and barriers to accessing resources. To ensure the relevance of the survey and informational resources, diversity and cultural safety considerations informed all aspects of this study. The survey was open for completion by home care providers for a two-week period in late 2021.

SURVEY ANALYSIS

We used descriptive analysis of both quantitative and qualitative data to identify preferred sources of support, barriers to access and gaps in the availability of supports.

Common barriers to accessing emotional support shared by PSWs, nurses and rehabilitation providers included not wanting to burden others with their emotional support needs and not having enough time to seek or use available supports. Providers from all groups expressed a strong desire for a personal connection with colleagues.

In response to the challenges identified through the survey and meetings with our advisory group, we created a directory of emotional support resources to help home care providers recognize when they need emotional support and to share appropriate, low- or no-cost options for support.

WHY THIS MATTERS

Staff at ETHP partner agencies who provide in-home care may have experienced similar challenges and could benefit from knowing about this resource. A recent Knowledge Transfer Symposium co-hosted by VHA and the Centre for Research Expertise in Occupational Disease revealed many community-based providers are in need of such information, but few have the time and resources to assemble high-quality resources.

THE FINAL PRODUCT

The "Refill Your Cup: Emotional Support Resource Directory" has been created and will soon be available on VHA Home HealthCare's external website. It is currently available on VHA's intranet and we have received positive feedback from providers and leaders regarding this resource.

Project Team:

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VHA Home HealthCare

Creating More Independence

ETHP ADVANCED CLINICAL PRACTICE FELLOWSHIP: BEST PRACTICE SPOTLIGHT OHT

East Toronto Health Partners

ABOUT THE FELLOWSHIP

East Toronto Health Partners (ETHP) was one of the first OHTs to enter the Registered Nurses' Association of Ontario's (RNAO) Best Practice Spotlight Organization® OHT designation program. In doing so, ETHP made a commitment to improve patient outcomes through evidence-based practice and robust staff engagement. The first Best Practice Guideline we implemented was **Person- and Family-Centred Care** (RNAO, 2015). RNAO offered ETHP the opportunity to support an Advanced Clinical Practice Fellowship to explore how clients with complex health conditions and their caregivers experience person- and family-centred care within an integrated care team in our OHT.

WHAT THE FELLOWS DID

Two interprofessional fellows, a nurse and a social worker, conducted an intensive qualitative study to learn from clients, caregivers and healthcare teams. The fellows conducted interviews, surveys, and a focus group to capture the client experience within the healthcare system and the enablers and barriers to integrated care. The fellows gained access to these clients, caregivers, and healthcare providers through the East Toronto Primary & Community Care Response Teams, a program that supports integrated care planning for adults with unmet health and social needs. The PCC Response Teams and care team approach aligns with the Best Practice Recommendation to develop a plan of care with the person to ensure that it is meaningful. This system collaboration ensures:

- Collaboration with the person to identify their priorities and goals for health care;
- Information is shared to promote an understanding of available options for health care so the person can make an informed decision
- The client is an expert on themselves and their life. (RNAO, 2015)

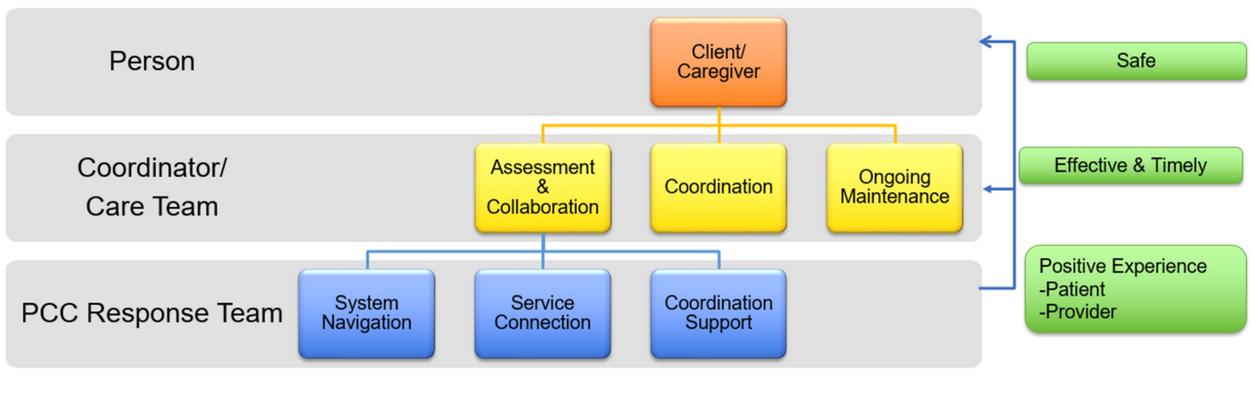
The fellows then analyzed the data through thematic analysis.

Kiel Ferguson (above) & Frances Montemurro (right), ETHP's Advanced Practice Clinical Fellows

Jennifer Reguindin (below) led the mentorship group for the fellowship.

THE FINDINGS

Outcomes of this work show that the client and caregiver experience is positive, safe, and effective through assessment and collaboration, which leads to coordination of the right support within the system. Thorough client assessment leads to improved system navigation, coordinated service delivery, and ongoing care maintenance.



Project Team

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BPSO RNAO Best Practice Spotlight Organization OHT — For integrated systems of care

Michael Garron Hospital — Toronto East Health Network

VHA Home HealthCare — Creating More Independence