

Table 2b: Promising Practices Grouped Examples

This table does not include all of the promising practices as described by the hospitals, and each promising practice has only been included in one categorical group although many of the initiatives could be placed in more than one group.

Examples of inter-agency partnerships

- The TIME (Together in Movement and Exercise _____) Program is a partnership with the City of Toronto Parks Forestry and Recreation, subsidized by the City of Toronto, to provide fitness programs for adults with stroke, Multiple Sclerosis and brain injury. Each client attends exercise sessions twice a week for a total of 12 weeks at one of two community centres. The first session was offered in the fall of 2007 and the classes have been full. More than half of the participants have signed up for repeated sessions. The need for this program was determined from feedback of inpatients.
- Mental Health Mobile Crisis Team is a joint partnership between the hospital and the Toronto Police Services. The program partners a mental health nurse and a police officer who respond to police dispatch or 911 calls involving emotionally disturbed persons in the south west end of Toronto. Majority of clients are homeless or underhoused, have low income, are living with chronic mental illness often complicated by medical co-morbidities, are dealing with substance abuse and are at high-risk of involvement with the criminal justice system. Out in the community there is a lack of access to interpreters however.
- Supportive housing initiatives in the Rockcliffe-Smythe and Oakwood-Vaughan neighborhoods were launched in September 2008 through a partnership between the Seniors Mental Health program at _____ and five to six other organizations. Service is provided, in a cluster care arrangement, to eligible seniors living in targeted apartment buildings in each neighborhood.
- Pro Bono Lawyer Program: An exciting new program that is a part of a partnership with Pro Bono Law Ontario providing an on-site lawyer to enable low income families the resources to address legal issues that may be an obstacle or barrier to care.
- Harm Reduction Case Manager: collaborative partnership discussions with PASAN (Prisoners with AIDS Support Action Network) to improve its harm reduction services specifically to PHAs with high risk behaviours or substance use issues.

Examples of inter-hospital partnerships

- Collaborative Task Force on Uninsured and Undocumented Clients: Formed in April 2007, as an initiative to develop a hospital and community health strategy for equitable access to health services for people without health insurance.
- LIFEspan is a partnered program between two rehab hospitals that is devoted to meeting the need of young adults who grew up with childhood neurological disorders or acquired brain injury. It is a recently funded TCLHIN initiative.
- Young Adult Program: Stakeholder engagement in 2007/08 identified the increasing pressures for the transfer of young adults with chronic disabilities and/or developmental/cognitive impairment to adult settings. The teams at both collaborating hospitals identified the unique requirements for this population and augmented existing services to meet their needs, including the design and retrofit of space for a cognitive stimulation treatment environment, recreational therapy enhancements and integration of the individual into local community education programs and/or services. A further improvement has been the development of a process for a time-sensitive transition of the young adult from across the continuum.
- _____'s CR Program is collaborating with _____ [community hospital outside TCLHIN] and _____ [critical care hospital in the TCLHIN] to provide cardiac prevention programs for frail elderly clients in the community.
- Day Health Program: a collaboration between two specialty hospitals to develop a Women's Case Manager Role to improve health for women with HIV/AIDS.
- Hemodialysis Support Program: Patients on hemodialysis (HD) who require slow paced rehabilitation following an acute episode and/or surgery have encountered limited access to multi-focused care. As _____ does not provide HD on-site we contacted _____ acute Hospital's dialysis team to collaborate. Activities included the development of processes and integration of clinical care activities . . . so that individuals access their regular HD at the acute hospital and reside at _____ for their rehabilitation/complex continuing care. Expansion of this initiative has included the transfer of individuals requiring HD from across the TC LHIN to _____ [this sub-acute facility] with _____ acute hospital providing these persons their dialysis. To sustain the access to this service the partner hospitals share the transportation costs for patients to/from the acute hospital.
- Patient Flow Partnership with _____ acute care hospital and _____ complex continuing care hospital involved closure of the Transitional Care Unit (a unit using Alternate Level of Care, or ALC beds) at _____ acute hospital, and redirection of these patients to this Hospital or _____ complex continuing care hospital. As a result of this plan, admissions from _____ acute care hospital to this Hospital have increased from about 7% of our admissions in 2008, to 20% so far this year -- a large number of those are homeless and vulnerable. With the support of _____ acute hospital's staff, we have provided education

and support for our front-line clinical staff, so that they can understand the particular needs of the homeless, and meet them with compassion and care.

Examples of community partnerships

- The James Bay Project is a collaborative Health Human Resources Demonstration initiative funded by the Ministry of Health and Long Term Care (MOHLTC). _____ staff nurses gain diverse experiences as a result of placement in the remote First Nations communities along the James Bay coastal areas of Attawapiskat, Fort Albany, Moosonee and Moose Factory. In addition, remote James Bay nursing staff can experience nursing practice in an urban environment.
- The Culture Counts Project--a best practices guide to creating and implementing health promotion initiatives that will have an impact in ethnocultural communities--was led by _____, the Ontario Public Health Association, and the Association of Local Public Health Agencies. The entire project was founded on a partnership between _____ and seven community based organizations serving Polish, Portuguese, Russian, Tamil, Punjabi, Somali and Serbian populations. This project serves as an exemplary community engagement process, and as a product narrates "dos and don'ts" stories from the partners' perspective. It also offers some links to valuable resources for community engagement.
- The Cardiac Prevention Program in partnership with _____ Community Centre provides a comprehensive program to assist those living with Type 2 diabetes to learn more about their health and healthy lifestyle behaviours. Typically diabetes education programs consist of education only. This program also addresses the need to be active and provides tools to assist patients to alter their lifestyle. The partnership addresses issues of transportation, financial and other ethno-cultural barriers.
- Diabetes Education Community Network of East Toronto (DECNET) is a partnership with _____ CHC, _____ CHC and this Hospital. The network provides empowering diabetes education aimed at effective self-management, with a focus on 'under-serviced' populations, such as specific ethno-cultural groups and individuals living with diabetes and mental illness. The program offers diabetes education classes, counseling and community support programs (community kitchens and community gardens) in community locations and in a variety of languages.
- Medical Outpatient Clinic participates in the Ontario Cohort study - one of the biggest HIV databases in the country through the Ontario Treatment Network (OTN) to advance treatment of HIV. The clinic social worker, along with four other HIV organizations and people with HIV, developed the Coalition on HIV and Mental Health which has evening therapy groups for people where there is a lack of services. In addition, clinic team members are involved in the Toronto Community Planning Initiative to coordinate HIV service in Toronto.

The clinic has established partnerships with a number of AIDS Service Organizations such as AIDS Committee of Toronto, People with AIDS Foundation, Voices of Positive Women, The Teresa Group and Black CAP as well as with other HIV Primary Care Physicians, the Clinic for HIV-Related Concerns at Mount Sinai Hospital which deals with mental health issues, Hospital for Sick Children and Women's College Hospital. All of the babies born to HIV+ patients have been HIV negative; over 80 per cent of patients on medication for HIV now have undetectable levels of HIV virus in their bloodstream; many patients are considering returning to work after long periods of disability, traveling and having children which speak to the quality of life issues.

- My Baby and Me Passport Incentive Program: The passport is a portable health record and information booklet for young pregnant homeless and underhoused women developed in collaboration with community partners. It motivates youth to attend prenatal appointments and improve communication between health care providers.
- The Virtual Patient Focus Group is comprised of former patients who have volunteered to provide advice on issues throughout the continuum of care at _____. The focus groups allow patients who may not be able to participate otherwise, to connect via computer to discuss and offer advice on proposed issues at _____. Presently, there are several hundred people participating.
- Solutions – East Toronto's Health Collaborative: The Healthy Connections 2008 conference provided an excellent opportunity for networking and discussion on health equity.

Mental Health and Addictions Programs

- Mental Health & Addictions Shared Care is a partnership between primary care practitioners (such as family physicians and nurse practitioners) and specialist services, which allows the responsibility of patient care to be divided according to the treatment needs of the patient. Approximately 400 family physicians participate -- the program enhances the knowledge and skill transfer between the acute and community inter-professional service providers, breaking down patient care treatment silos.
- The Asian Initiative in Mental Health is a service that is focused on enhancing the provision of culturally competent mental health services to the Chinese Community in Cantonese and Mandarin. _____ is a member of the Chinese Mental Health Network, which has the objective of enhancing mental health capacity, and is a founding member of the Early Intervention in Psychosis Network.
- Central Access Withdrawal Management Service is a central access telephone triage and service matching program with the other Withdrawal Management Services [at three other hospitals in the TCLHIN].
- PHA ACCESS Clinic for HIV-Related Concerns is a community-based

research project testing a model of community-hospital collaboration, knowledge exchange, and capacity building, aimed at increasing access of people living with HIV to mental health services by training and supporting AIDS service organization.

- Behavioural Neurology Unit provides five MOHLTC funded beds for clients from nursing homes with dementia and severe behavioural challenges (e.g. aggression, agitation, sometimes violent, etc.). Beds were designated in response to the Casa Verde Inquest to address the needs of seniors considered 'revolving door' patients and 'difficult to place' within the system.
- Geriatric Psychiatry Community Services provides outreach to in-home and outpatient older adults (65+) experiencing psychiatric conditions/mental health issues.

Capacity Building

- Community Research Capacity Enhancement Program (CRCEP): Launched in 2004 to enhance research interactions with community partners and to help build research capacity among organizations that address addiction and mental health issues in Ontario; has as a priority focus on projects focused on reducing mental health and addiction disparities and building relationships and capacity in diverse, marginalized communities.
- The Hospital is working collaboratively with northern, remote Ontario communities to provide specialized services and clinics through Telehealth videoconferencing. Examples include dental services, cleft lip and palate and neuromuscular clinics.
- Southwest Ontario Area: In fall 2008, this hospital created a knowledge framework that can be shared with stakeholders and can provide a foundation to identify gaps and build solutions that will improve access to local mental health and addiction services.
- Telehealth: Health care services for patients and families as well as education for health care professionals are provided at _____ through the use of live two-way videoconferencing systems, digital stethoscopes and high-resolution patient examination cameras, to overcome barriers to access due to geography, time, distance, and lack of specialists in rural areas.

Outreach

- Community Outreach Assessment & Treatment Team provides outreach services and in-home support to frail, isolated and home-bound older adults (55+) with complex health, functional and social issues in need of a complete geriatric assessment.
- Visiting Dietician Program: A large proportion of medically complex children have elevated nutritional requirements that are complicated by fluid

restriction, malabsorption, electrolyte imbalance, and food intolerance. Highly specialized paediatric nutritional care in the community is required but seldom available. In this program, children initially receive eight home visits by a dedicated Hospital "Link" dietitian who completes a nutritional assessment and works with families to develop care plans.

- Acquired Brain Injury Behaviour Services (ABIBS) Outreach Program provides outreach services to adults with an acquired brain injury and challenging behaviours who primarily live at home, or in other hospitals or assisted living facilities; assists clients and their families/caregivers to learn to reduce and manage the challenging behaviours that interfere with normal home life. Behaviour therapists work with clients and their families/caregivers over a 6-9 month timeframe through a series of sessions. A study was conducted to evaluate the impact of the ABIBS Outreach services -- participants in the study were noted to achieve or exceed their treatment goals related to anger management and increasing community integration, but did not meet expected goals relating to activities of daily living.
- Inner City Health Associates Physician Outreach to shelters & hostels with 30 sites and 37 physicians currently participating from numerous hospitals in Toronto; assists in the implementation of the CAISI project; increases patient access to information and promotes stronger integration of health and social services.
- The psychogeriatric outreach team consults on the management of patients with dementia related problems and challenging behaviours that result from dementia. The team, comprising a physician and clinician, make recommendations to enhance the safety and management of a patient in the home. Partner with _____ [acute hospital], several long term care homes including a Chinese one; and two retirement homes.

Outpatient and Rehabilitative Services

- Comprehensive Spasticity Management Clinic formally established in 2008; the hallmark of the clinic is an inter-professional care model that provides for a full range of treatments for a medical condition that is under-recognized, under-diagnosed and under-treated, to improve functional independence and quality of life.
- Spinal Cord Rehabilitation outpatient therapy services are specifically designed for adults with spinal cord injury and services clients both within and outside the GTA (over 40% of clients live outside of Toronto). Social work and psychology out-patient services support people with SCI and co-morbid mental health or cognitive challenges to access physical rehabilitation.
- Spinal Cord Program Fitness Centre serves 88 patients per year and 4931 visits. The Fitness Program began as a 6 month pilot project in February 1997 as a joint initiative between Physiotherapy and Therapeutic Recreation. The program has evolved and clinical involvement is on a consult basis only; is

partially funded through operating dollars and through monthly membership fees for clients.

- _____ identified the need for increased access to slow-paced rehabilitation for individuals presenting with multiple co-morbidities, chronic disability, and/or socioeconomic challenges. The slow-paced rehabilitation program implemented in 07/08 was designed to provide admitting criteria that diminished the barriers to accessing services for individuals with rehabilitation goals and socioeconomic challenges such as discharge destinations into sub-optimal housing requiring harm-reduction as a key part of their care plan.
- Patients with hemophilia requiring both rehabilitation/restorative and complex continuing care following an acute episode and/or surgery have experienced limited access to inpatient rehabilitation as a result of their unique treatment needs. In 2007/08 this hospital identified through referral data and stakeholder engagement that this population, young and old experienced limited access to post-acute care. To meet these needs this hospital collaborated with _____ acute hospital's hematology team to train this hospital's staff on the provision of Factor 8 medication vital to the care of the persons with hemophilia. As a result of this initiative, patients do not require daily transfers back to acute care hospitals for their medications.
- The IMPACT Clinic is an initiative of this Hospital's Department of Family and Community, in partnership with this Hospital's Department of Pharmacy and local community services. It provides a unique model of care for seniors 65+ with multiple chronic illnesses who have various barriers that make it difficult for them to navigate the system; it provides them with an integrated holistic model of care. The interprofessional health care team sees patients and family care-givers together and provides a comprehensive assessment and management plan, co-created with the patient and family members. This integrated model of care helps to ensure that patients have their needs addressed at one time. For older seniors, this is much more manageable than having separate, 15 minute appointments with the various specialists they may require.
- The Elderly Community Health Services (ECHS) include: Geriatric assessment and intervention; Rehabilitation; Health education; Supportive counseling; Placement planning; Referrals to other services as needed. The Community Outreach team, comprising an occupational therapist, physio-therapist and social worker, will do home visits if the patient/client has a challenge to come to the ECHS clinic.
- Family Medicine Centre + Family Health Team offers primary care services in reproductive care, obstetrics, health assessments, diagnosis and treatment, palliative care and mental health and additions. Additionally, services include home visits, after hour's office care and 24/7-telephone care. Serves recent immigrants; individuals experiencing chronic mental illness; individuals with substance use disorders; elderly persons including frail housebound seniors; women who are victims of violence; and low-income single-parent families. Many of the patients experience significant barriers to receiving care within

the health care system. Urban Family Health Team provides primary care for many vulnerable clients who are living in marginalized conditions.

- ACWC (Augmentative Communication and Writing Service) and Speech Language Pathology Service is a specialized service that addresses the communication needs of individuals with severe speech and/or physical impairments through the provision of augmentative and alternative communication (AAC). ACWC provides service on both an in-patient and out-patient basis.

Family and caregiver support

- Family Caregiver Connections – partnership between six agencies to provide free support to caregivers of seniors living in the community who might not be aware of or engaged with formal supports
- Private Companion Program -- over 600 companions hired by family members to support clients and help clients access health services, programs and other activities. Companions are oriented to ensure they do so in a safe and effective manner.
- Financial Support Fund through the Hospital Foundation, children with physical disability and their families can access financial assistance for the following expenses: Adaptive equipment, Medications, Recreational programs, Transportation costs, Cost of meals and accommodation.
- Playroom (Onsite Daycare for Clients and Siblings): Many families who come to the Hospital find inadequate child care supports a significant barrier to accessing health-care resources for their child.
- The Tamil Caregiver Project: Helps mostly Tamil-speaking refugees from Sri Lanka who are newcomers to Canada who are caring for ailing family members. The program provides support, recognition of their difficulties, education and information about access to health care services. The program conducts many mobile workshops and seminars (topics such as diabetes awareness, heart and stroke, end of life issues, elder abuse, healthy life style, etc.) in Tamil, English and in American Sign Language.
- Alzheimer Day Program: The nationally acclaimed Alzheimer Day Program was the first program of its kind in Canada when it was developed, and is now used as a model for other similar facilities. The program is based on a 'club concept' where care is provided 24 hours a day for five days of the week, and during the day on the weekends. Clients are called 'club members' to ensure dignity and respect. During their time spent at the Alzheimer Day Program they are introduced to a number of programs geared to their specific areas of need and of interests, ranging from baking, woodworking, gardening, music therapy, and even visits with the program's pet therapy dog Monty. Caregivers benefit from a much needed break, or are able to continue their employment duties.

- Development of technologies to assist Family caregivers who make it possible for people with disabilities to continue living at home and to reduce the burdens on the caregivers.
- Family Support Service for families who speak Spanish, Portuguese and Italian and who have a family member who is experiencing mental illness or substance use.

Education

- The Patient Relations Road Show attended by over 1000 staff offers front-line staff a hands-on, practical approach to patient relations and teaches ways to be responsive to patient needs.
- The Patient Education Network (PEN) coordinates hundreds of multilingual translation projects of patient education materials each year, while providing training to clinicians on plain language and health literacy. PEN's course on patient education features the "teach back" method, an important approach for patients with limited English proficiency, low health literacy or cognitive limitations.
- _____'s Human Resources Department supports a series of workshops both for managers and front-line staff to develop an 'inclusive' working environment. In these 2.5 hour sessions, participants confront some of the barriers to ensuring staff feel included in their work environments and are not excluded based on cultural, gender, religious or other factors.
- _____'s Veterans Centre has created a session for caregivers to improve communication between families and staff. The mandatory day-long workshops for staff and for family members of Veterans helps find common ground in ensuring the healthcare team understands the unique needs of residents and their families and it helps family members understand the care model that is provided at _____.
- Talk to Me: Violence Against Women Awareness Program: Health care providers are trained to recognize signs; they wear buttons that announce that if the patient or children are abused they can talk to the health care provider; posters and brochures in various languages are placed throughout the hospital. These initiatives aim to change the culture of healthcare settings by promoting a safe environment for the disclosure of IPV -- relay that they are approachable, and open to disclosures of IPV.
- _____'s free, online "Mental Health and Addiction 101" tutorials have broad reach and the potential for system-level impact (more than 300,000 have accessed them).
- Diversity related educational events/projects (internal):
 - ✓ Established an Education Council with a diversity/equity commitment as part of its mandate.
 - ✓ Introduction to Diversity training – Mandatory for all non-management staff.

- ✓ Diversity for managers/supervisors - Introductory training for all management.
- ✓ Asking the Right Questions (ARQ) 2 - Training to help clinicians increase their repertoire of appropriate questions and approaches to serving clients from marginalized sexual orientations and gender identities.
- ✓ Cultural Competency (clinical, management, other staff – in process) – Training to give clinicians the knowledge, skills and attitudes to work effectively with a diverse client population.
- Web based interactive learning tool to assist medical students in learning to work more sensitively with patients from marginalized backgrounds such as the homeless – currently being developed by Psychiatrist Dr. Heather MacNeil working in partnership with U of T.