

**Table 2a: Promising Practices**  
**Table of hospital responses**

**Q.** 2a) Please briefly describe a maximum of 5 current hospital initiatives that help to improve access to health services by underserved or underrepresented populations?

**Which population do they target and/or which access barrier do they seek to remove?**

**In what ways is success being measured and what outcomes yielded as a result? Please provide samples of related documents if any.**

Hospital 1: Complex continuing care and acute care	
Community Outreach Team	<p>No-fee comprehensive, multi-disciplinary home-based services are concentrated in disadvantaged areas and communities with the greatest need.</p> <p><i>Community Outreach Assessment &amp; Treatment Team (COTT)</i> – 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.</p> <p><i>Geriatric Psychiatry Community Services (GPCS)</i> – provides outreach to in-home and outpatient older adults (65+) experiencing psychiatric conditions/mental health issues.</p>
Specialized Services for Unique and ‘Hard to Serve’ Seniors	<p>_____ offers highly specialized programs that prevent older adults from being excluded from the system due to their behaviour, mental health issues and/or cognitive limitations.</p> <ul style="list-style-type: none"> <li>-Behavioural Neurology Unit (4W) – 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.</li> <li>-Fronto-temporal Dementia (FTD) Program in Community Day Centre for Seniors – customized program provides adult day care services to clients and fills a gap in day program availability for a younger population.</li> <li>-Café Europa / Holocaust Resource Program – Café Europa is a weekly drop in place for Holocaust survivors with declining physical and/or mental health issues to relax, socialize and access a range of services (e.g. transportation, meals, entertainment, socialization, cultural).</li> </ul>

Community Supports	<p><i>Senior Support Program (SSP)</i> – friendly weekly telephone service offered in the language of preference to home-based seniors who are isolated due to health and/or psycho-social issues. Additional services recently added: an e-Pal service for seniors who prefer electronic friendly contact, support for graduates of the Toronto/York Public Health Falls Intervention Program (FIT) and VOIP phone services as a partner of the Doorways to Care Initiative.</p> <p><i>Family Caregiver Connections</i> – 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 (e.g. holocaust survivors, new immigrants, non-English speaking, living below LICO, etc.)</p>
Navigation & Coordination of Services (Internally & Externally)	<p>Navigating the health care system is reported as the number one barrier to health, in particular for older adults and vulnerable populations (Elder Health Think Tank, 2006).</p> <ul style="list-style-type: none"> <li>◆ Seniors &amp; Caregivers Intake &amp; Referral Service -- help with navigating and accessing the health, long-term care and social service systems. Support is provided in a culturally sensitive manner and the language of preference.</li> <li>◆ 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.</li> </ul>
Wellness & Day Treatment Programs	<p>In particular those experiencing complex medical and psych-social issues</p> <ul style="list-style-type: none"> <li>◆ Day Treatment Programs – includes Psychiatric Day Hospital for Depression, Day Treatment Centre (Community Treatment Team), and Geriatric Assessment &amp; Treatment Unit (GATU). Programs provide short-term outpatient and support services. Programs act as an alternate to lengthy hospitalization and/or support post hospitalization.</li> <li>◆ Brain Health Centre Clinics – outpatient service that provides the community with access to three highly specialized clinics that focus on: Memory, e.g. Alzheimer’s FTD, MCI, abnormal behaviour, etc.; Mood &amp; Related Disorders, e.g. depression, bipolar mood disorders, bereavement, anxiety, etc.; and Stroke and Cognition, e.g. stroke survivors with cognitive impairment.</li> <li>◆ ‘Fitness Circuit’ – provides frail seniors who experience a range of health challenges (e.g. stroke, diabetes, heart disease, Parkinson’s, etc.) with health, recreational and wellness programs. The ‘Fitness Circuit’ offers rehabilitation centres and hospitals with a range of appropriate programs where seniors can be referred to maintain their rehabilitation gains and/or prevent further deterioration or secondary disease.</li> </ul>
<b>Hospital 2: Rehab</b>	
Client and Family-Centred Care (CFCC)	<p>Client and family-centred care has a significant influence on positive health-care interactions involving all clients and it ensures that care is customized to the clients’ and families’ needs and values, and according to their diverse background and challenges.</p>

	<p>-Facilitated café conversations for staff, clients and families          -CFCC committee          -CFCC survey to staff, clients and family members</p> <p>Current Leading practices in client and family-centered care are:          Family and Youth Advisory Councils          Family Support Programs and Family Resource Centre          Board members, the President and CEO and the Vice-President of Programs and Services attend the Family Advisory Council that meets monthly.</p>
<p><b>Family Support Programs</b></p>	<p>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.</p> <p>Onsite Accommodations: Ten onsite fully accessible suites are available for parents and caregivers who require overnight accommodation. Parents can book a suite for a nominal fee; however, no family is refused access to accommodations because of financial reasons.</p> <p>Interpreter Services: professional interpreter services free of charge, any appointment, family meeting or activity at Hospital. Hospital uses Multi-Languages Corporation, Access Alliance and hospital staff who have completed onsite interpreter training.</p> <p>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.</p> <p>The Resource Centre: It is an open and inviting space adjacent to the main reception, library, cafeteria and Playroom. Clients and families are encouraged to access information on programs and services offered at the hospital, use the computers to access information on the web, access support and find help navigating the system through the Family Resource Centre Staff. The centre loans equipment such as car seats and bikes for trial.</p> <p>The Family Relations Coordinator (FRC): FRC provides information about community resources and develops education sessions to strengthen the family's role as advocates for their child.</p>
<p><b>Partnerships and Advocacy</b></p>	<p>Partner and collaborate with our clients and their families through the Youth Advisory Committee and the Family Advisory Committee. We work with others to advocate around policy changes and systemic improvements that will benefit children with disabilities and their families. Our involvement in networks and partnerships is critical to building capacity in agencies and across the pediatric continuum to better support children with disabilities in their community. Examples include advocating for affordable, accessible housing</p>

	and membership on the Child Health Network.
Building System Capacity	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.
<b>Hospital 3: Complex continuing care and disabilities</b>	
Vocational Rehabilitation Services	The Hospital's day treatment program offers vocational rehabilitation services to patients who could benefit from getting back into the work force. The service is the only publicly funded vocational rehab service available in the GTA.
ACWC (Augmentative Communication and Writing Service) and Speech Language Pathology Service	The Hospital's ACWC 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.  In addition, the Hospital also has a speech and language service that provides each patient with aphasia and dysphasia access to assessment and the design of an individualized speech and communication plan.
Seating Service Assistive	Seating devices are customized for our patients on-site and free of charge. Staff work with patients in accessing grants and funding to allow them to purchase high-cost items that would normally be out of the grasp of patients with low incomes.
Language and Cultural Interpretation Services	Hospital-wide translation and cultural interpretation service -- The service uses both in-house staff translators as well as outside contracted translators. A full time translation coordinator is responsible for managing the service
Educational Tools for Physicians working with Marginalized Populations	Physiatrist Dr. Heather MacNeil, is currently working in partnership with U of T to design a web based interactive learning tool to assist medical students in learning to work more sensitively with patients from marginalized backgrounds such as the homeless. The expected outcomes of this tool for the learner include gaining content knowledge but also significant attitudinal change towards providing care and learning in an interprofessional format. It is expected that participants will be exposed to "clinical pearls" from other learners and professions.
<b>Hospital 4: Specialized Clinical care</b>	

Population-specific addiction programs	Developed to address underserved populations: LBGTTQQII, Portuguese-speaking, African Canadian youth, Spanish-speaking, women, aboriginal people, heroin users. Success: Client retention, client self report of progress, specific outcome measures i.e. BASIS 32 (Outcome measurement tool), program utilization, community feedback.
The Centralized Assessment Triage and Support (CATS) Program and the Information Centre	Centralized 1-800 access for addiction and mental health information and resource materials in several languages other than English, currently Portuguese, Spanish, simplified Chinese (read by both Mandarin and Cantonese –speakers), Punjabi, Polish, Somali, Urdu, Farsi, Greek, Hindi, Italian, and Tamil. Also provides facilitated access to addictions and mental health program liaison staff to schedule an assessment and/or obtain further information on specific services. Cultural Interpretation Services of the CATS program provides interpretation and translation service to all hospital clients/patients, which may also highlight cultural nuances. This service provides in-service sessions to outpatient (including satellite clinics) and inpatient staff on how to work with interpreters. Currently developing an evaluation tool that uses a quality assurance database.
Substance Abuse Program for African Canadian and Caribbean Youth (SAPACCY)	A holistic service and the only of its kind in Canada, engaging the Black Diaspora in as direct service providers and as a conduit to other responsive end-service providers.
Child Youth and Family Adolescent Service	The service does court appointed assessments; manages a caseload that serves over 50% members of racialized communities.
Cultural Competence and Physicians' Leadership	Intra-organizational collaboration focuses broadly on equity and diversity leadership at the senior clinical level with an emphasis on bias-free hiring, and on developing strategies to effectively measure and monitor clinical outcomes related to marginalized communities. Sessions will begin in April 2009.
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. Examples of successful projects: <ul style="list-style-type: none"> <li>○ The Development of a Problem Gambling Screening Instrument for Older Patients</li> <li>○ The Experience of Families of People with Developmental Disabilities in Crisis.</li> <li>○ Assessment of Mental Health Needs of the Thai Population in Ontario</li> <li>○ Mental Health Experiences of Government Assisted Refugees</li> <li>○ Transnational Research on Refugee Youth Coping Strategies</li> <li>○ Prescription Opioid Injection Among Street Drug Users in Toronto</li> </ul>

	<ul style="list-style-type: none"> <li>○ Creating Links Through Research</li> <li>○ Bisexuality, Mental Health and Emotional Well Being in Ontario</li> </ul>
Provincial Services	<p>Engages local communities to advance best and promising practices throughout the health continuum. Examples:</p> <ul style="list-style-type: none"> <li>• Introduction to Diversity: Training to increase diversity awareness and improve cultural competency for service providers</li> <li>• Healthy Aging Project: Enhance identification, screening, assessment, referral and treatment for diverse groups of older adults who have a substance use, mental health and/or gambling problems</li> <li>• Iranian Stigma Project: Address stigma in the Iranian Canadian community through a number of culturally appropriate activities to increase knowledge of mental health, addictions, and concurrent disorders</li> <li>• Southwest Ontario Area: In fall 2008, 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.</li> </ul>
Health Promotion Initiatives that address Social Determinants of Health	<p>Culture Counts: 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.</p> <p>Youth -Strengthening Families: Skills development program designed to reduce risk factors &amp; enhance protective factors of children age 7-11 whose parents have a history of alcohol &amp; other drug use problems. A 5-year research project, in partnership with the University of Buffalo, to evaluate the Canadian version of the program was completed in 2005. The program guide was produced in 2006 and entered into the dissemination phase in 2006. Implemented in local at-risk communities.</p>
Published resources	<ul style="list-style-type: none"> <li>▪ Bridging Responses: A Front-line Workers' Guide to Supporting Women who have Post-traumatic stress -- in health care, literacy, corrections, housing and other community services.</li> <li>▪ Working with Immigrant Women: Issues and Strategies for Mental Health Professionals.</li> <li>▪ Homeless and Street Involved People Housing Guide 2004-2006: A Comprehensive Guide for People with Mental Health and Addiction Concerns</li> </ul>
Education Services	<p>_____’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).</p>

	<p>Diversity related educational events/projects (internal):</p> <ul style="list-style-type: none"> <li>• Established an Education Council with a diversity/equity commitment as part of its mandate.</li> <li>• Introduction to Diversity training – Mandatory for all non-management staff.</li> <li>• Diversity for managers/supervisors - Introductory training for all management.</li> <li>• 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.</li> <li>• 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.</li> </ul> <p>Diversity related educational events/projects (external):</p> <ul style="list-style-type: none"> <li>• Provincial Intro to Diversity &amp; “ARQ2” trainings (started 2002-2003)</li> <li>• “Mental Health and Addiction 101” series (launched 2008)</li> </ul>
<b>Hospital 5: Specialty</b>	
Harm Reduction Case Manager	_____ is in 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.
Women's Case Manager	_____ is in discussions to sponsor a community resource to enhance services for women with HIV/AIDS who are considered "hard to reach." This includes women from diverse ethno-cultural communities and highly marginalized groups (e.g., low income, under-housed). The Woman's Case Manager is envisioned to meet/connect with women at Voices of Positive Women, Women's Health in Women's Hands or to work with women in their residences or preferred environment of care.
Psychotherapist	This Hospital is in collaborative discussions with _____ acute hospital to establish group and individual psychotherapy services to address individual and group mental health needs of PHAs at risk for deteriorating health. The psychotherapy services to be offered in the Day Health Program.
Sherbourne Health Bus	_____ is reaching out to the homeless and under-housed HIV positive population as well as sex trade workers through a sponsor partnership with the Sherbourne Health Bus. _____'s registered nurses work on the Sherbourne Health Bus.
Toronto Community Planning Initiative Housing Working Group	_____ is active in the TCPI Special Housing Working Group to further meet the needs of Toronto's HIV/AIDS hard to house population.

<b>Hospital 6: Specialty</b>	
Visiting Dietician Program	_____ has a diverse and complex patient population; many who need intense nutritional therapy post-discharge. 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. This dietitian completes a nutritional assessment and works with families to develop care plans, in collaboration with Hospital staff. If goals are not met, visits can be added. When goals are achieved, children are discharged from the program.
Patient Amenities Fund	Poverty is a key barrier to achieving health equity for children. Consequently, in order to mitigate financial barriers to care and recovery, _____ partnered with the Hospital Foundation to create an essential financial resource for low income families and those living in poverty. The Patient Amenities Fund is a composite fund which is administered through the Department of Social Work and encompasses financial supports, including the Parent’s Personal Services and the MultiOrgan Transplant Fund. In the last fiscal year, 940 families were assisted and a total of \$204,449.00 was administered to assist these families. In the current fiscal year, we are forecasting an increase in the number of families facing financial hardships that impact their child’s care. In recent years a special fund, the Unforgetables Fund, was created by a committed group of physicians and others in the community to ensure low income families are able to provide a funeral for their child in the event of his/her death. The hospital has also partnered with the Canadian Cancer Society and the Paediatric Oncology Group of Ontario to administer funds raised by these groups to cancer patients cared for at _____.
NICU Research Study	Immigrant families tend to face challenges including language barriers, little to no support network etc. _____ recognizes this fact and in 2008 the NICU team was engaged in a research study examining cross-cultural healthcare within a neonatal setting. The purpose of which was to improve our understanding of the experiences of immigrant families and their health care providers in the delivery of health care services. Results are pending.
Pro Bono Lawyer Program	An exciting new program that is a part of a partnership with Pro Bono Law Ontario will see the introduction this spring of a Family Health Legal Program which will include an on-site lawyer to enable low income families the resources to address legal issues that may be an obstacle or barrier to care. This program will comprise three components: 1) education to health care professionals about legal issues that may impact child health, 2) services of a triage lawyer to assist children and families or connect them with pro bono legal services in their home community, 3) systemic advocacy to promote social justice.
The _____ Initiative in Complex Care	The Department of Paediatric Medicine at _____ recognizes the gaps that exist in our present system and have created a complex care program to better serve this population. The innovations that this program provides include: 1) A specialized inpatient team run by a nurse practitioner and a physician experienced in the delivery of complex care.

	<p>2) A Written Care Plan (electronic document) that functions as a medical passport for the child, so that all health care practitioners involved in the child's care are kept 'in the loop' of what the child needs- this is especially helpful when English is not a first language. The usefulness of these care plans from a parent, patient and health care provider perspective is currently being investigated by our team.</p> <p>3) A real and a virtual Complex Care Clinic which provides and coordinates care from a holistic perspective for this population and makes paediatricians and nurse practitioners accessible to parents outside of the hospital setting. Families can call or email clinicians and get rapid answers to their questions and concerns. This program helps to ensure continuity in treatment, prevent crises and reduce the need for hospitalization and emergency room visits. A recent study was completed by our team to evaluate the impact of a nurse practitioner/hospitalist-run complex care clinic in a tertiary care hospital on health care utilization, parental and primary care provider perceptions of care and parental quality of life. The study demonstrated that this kind of clinic can improve efficiency of resource utilization, parental and health care provider satisfaction with hospital-based care, and quality of life for parents of medically complex children. In addition to ____ site we have developed a new intervention that is aimed at providing integrated community-based care coordination in collaboration with our tertiary care children's hospital to provide complex care clinics to medically complex children in their own community. We have partnered with two regional centres (_____ in Brampton and _____ in Orillia) to evaluate this model.</p>
<p><b>Hospital 7: Acute</b></p>	
<p>Gateways to Cancer Screening: A Participatory Needs Assessment of Women with Mobility Disabilities</p>	<p>Includes addressing barriers of past negative experiences with health screening, healthcare system (multiple constraints and delays), transportation, lack of knowledge by individuals and healthcare professional's knowledge regarding cancer screening &amp; people with disabilities, as well as architectural, attitudinal, socioeconomic barriers.</p>
<p>Talk to Me: Violence Against Women Awareness Program</p>	<p>Health care providers are trained to recognize signs; they wear buttons that announce that if patient or children are abused they can talk to health care provider; posters and brochures in various languages placed throughout 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.</p>
<p>Association for the Advancement of Blacks in Health Sciences (AABHS) Summer</p>	<p>To encourage future black and aboriginal health care providers. _____ is the largest site for this program, taking 16 out of the total of 20 students for the GTA. Graduates of the Mentorship program have successfully entered Medical School and other health professions.</p>

Mentorship Program	
Assertive Community Treatment Team (ACTT)	This is the only ethnocultural ACT Team in Canada. The team responds to community needs by hiring diverse bilingual staff to reflect recent immigration and settlement patterns. The team has demonstrated exceptional outcomes with respect to reduction of hospital days and psychiatric admissions as compared with its mainstream counterparts.
PHA ACCESS: Clinic for HIV-Related Concerns	ACCESS project 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 (ASO).
<b>Hospital 8: Sub-acute</b>	
'Flo Collaborative' with _____ acute care hospital	This initiative was conducted in partnership with _____ acute care hospital, with an aim of improving the flow of patients through general internal medicine beds by improving the processes underlying the transition of patients between _____ acute hospital and this Hospital. The project has improved the flow of patients between the facilities significantly since its beginning in 2007.
Patient Flow Partnership with _____ acute care hospital and _____ complex continuing care hospital.	This initiative 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.
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. This project was initiated in 2000 to respond to the high concentration of Tamils in Toronto, specifically in Scarborough where _____ is located. The project was initially supported through the J.W. McConnell Family Foundation, then became a partnership with the (then called) Scarborough Community Care Access Centre, and is now supported through funds raised by the Tamil business community. The Project's goal is to facilitate understanding and access to respite as a quality-of-life outcome. 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. These are widely publicized through the Tamil community in a variety of ways including the ethnic media, in the Tamil business community, and in churches and temples. As part of the Tamil Caregiver Project, a unique service

	was developed to support the spiritual needs of ailing Tamils in the community. On request, trained Tamil/Saivite/Hindu spiritual workers visit Tamil individuals in partnering hospitals and long-term care homes.
Low-tolerance Stroke Rehabilitation Program	Low-tolerance stroke rehabilitation is an innovative program that was pioneered within _____, and since that time has been adapted by other health care facilities. The program is designed for individuals who have had a stroke or other neurological event, but due to their physical limitations and multiple complex conditions, do not have the endurance or tolerance for active rehabilitation. Yet these patients still have the potential for rehabilitation recovery. Through the low-tolerance stroke rehabilitation program, a more gradual type of rehabilitation therapy is provided. Most recently, a number of enhancements have been made to the program including the development and introduction of a unique stroke education program with a toolkit of informational materials given to each patient. The highlight of the toolkit is a made-at-_____ DVD featuring a number of recovering patients and clinical professionals. During 'on-camera interviews', these people explain simply and clearly many of the aspects of stroke, and the elements that are essential to a successful recovery (lifestyle, smoking cessation, nutrition, exercise, medication, etc.). The low-tolerance stroke rehabilitation program is a key program because it services a group of people who are not good candidates for active rehabilitation programs, and might otherwise be placed in long-term care or back in the community without the appropriate level of support needed to maintain the activities of daily living.
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.
<b>Hospital 9: Specialized complex continuing care</b>	
Website	In striving to maximize return on investment _____ has greatly expanded its website to provide for a variety of information including timely articles and other education materials, contact information, linkages and alike that support health equity goals.
Hospital communications strategies	Looks to support a culture of equity, collaboration and innovation among staff, physicians and volunteers.
Community engagement	Engagement of the community the Hospital serves, giving presentations and providing information, reports, etc. as appropriate. For example in the later part of 2008 senior _____ staff provided presentations to 3 local

	<p>service groups. In so doing, the Hospital targets a broad group of the community that themselves often work with underserved and underrepresented populations such as seniors and the poor.</p>
Patient Advocate	<p>_____ ensures that all patients have at their disposal an advocate; typically the Hospital's Social Worker fulfills this role. This is especially important for many of our seniors who often find themselves without family and/or friends to act as a champion of their cause.</p>
<h2>Hospital 10: Community and Specialty</h2>	
Mental Health & Addictions Shared Care Programs	<p>Shared Care is a partnership between primary care practitioners (such as family physicians and nurse practitioners) and specialist services. It allows the responsibility of patient care to be divided according to the treatment needs of the patient. _____'s Mental Health Shared Care Program provides:</p> <ul style="list-style-type: none"> <li>• comprehensive bio-psychosocial assessments;</li> <li>• practical diagnosis;</li> <li>• detailed treatment recommendations; and</li> <li>• the availability of on-going support by an interprofessional practice Shared Care Team to community family physicians.</li> </ul> <p>Approximately 400 family physicians participate -- the program enhances the knowledge and skill transfer between the acute and community interprofessional service providers, breaking down patient care treatment silos. Also expanded to addiction services, many who suffer with concurrent mental health disorders.</p>
Mental Health Mobile Crisis Team	<p>A joint partnership between _____ 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 person 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.</p>
Family Medicine Centre + Family Health Team	<p>The Centre offers primary care services in reproductive care, obstetrics, health assessments, diagnosis and treatment, palliative care and mental health and addictions. Additionally, services include home visits, after hour's office care and 24/7-telephone care.</p> <p>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.</p> <p>Urban Family Health Team provides primary care for many vulnerable clients who are living in marginalized conditions.</p>

<p>The Elderly Community Health Services (ECHS)</p>	<p>Services offered through ECHS include:</p> <ul style="list-style-type: none"> <li>• Geriatric assessment and intervention;</li> <li>• Rehabilitation;</li> <li>• Health education;</li> <li>• Supportive counseling;</li> <li>• Placement planning;</li> <li>• Referrals to other services as needed.</li> </ul> <p>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. The clinic itself is easily accessible physically; courtesy volunteers stationed at entrance points also assist; a frequent user of interpreter services. In order to promote ECHS services in the community, team members from time to time participate in Health Fairs or give talks to community groups upon request.</p>
<p>The Toronto Centre for Substance Use and Pregnancy T-CUP</p>	<p>A provincial referral centre for pregnant women with substance use disorders, as well as care of newborns that have been affected by substance use. Care is tailored to each client using cognitive-behavioural strategies designed to enhance motivation and promote behavioural change.</p>
<p><b>Hospital 11: Acute</b></p>	
<p>Central Access Withdrawal Management Service (WMS)</p>	<p>_____ administers a Central Access telephone triage and service matching program with the other Withdrawal Management Services [at three other hospitals in the TCLHIN].</p>
<p>My Baby and Me Passport Incentive Program</p>	<p>The passport is a portable health record and information booklet for young pregnant homeless/underhoused women developed in collaboration with community partners. It motivates youth to attend prenatal appointments and improve communication between health care providers.</p>
<p>Homeless Balanced Scorecard</p>	<p>Development of a tool to measure economic evaluation of health services provisions vs. patient satisfaction and health outcomes to assess and improve care of homeless patients.</p>
<p>Rotary Transition Centre</p>	<p>The Rotary Club of Toronto - Transition Centre provides a temporary safe, welcoming and hospitable</p>

and Emergency Dept. Community Worker	environment for homeless and underhoused individuals who have been referred through the Emergency Department (ED). The Community Worker is a paid position within the ED, who has direct experience of homelessness, provides welcome and navigation for vulnerable patients. ~1,000 patients/year use the Transition Centre and ~9,000 visits in the ED are identified as homeless or underhoused.
Client Access to Integrated Services and Information (CAISI)	The CAISI Project, currently in its infancy, is working to end chronic homelessness. It will allow clients who are homeless to enhance the quality of their life by accessing and controlling improved integration of services between agencies at the individual and population levels using an open source electronic information system.
Inner City Health Associates	Physician outreach to shelters & hostels initiated by _____ physicians. This network currently includes physicians from numerous hospitals in Toronto. 30 sites and 37 physicians are currently participating; Assists in the implementation of the CAISI project; Increases patient access to information and promotes stronger integration of health and social services.
Research Centre	_____ is Canada's first and only transdisciplinary and hospital-based research centre dedicated to reducing health disparities and improving the health of socially and economically disadvantaged urban populations.
<b>Hospital 12: Critical care</b>	
IMPACT Clinic: Interprofessional Model of Practice for Aging and Complex Treatments	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 in the same way the mainstream population can. 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.
Medical Outpatient Clinic	The outpatient clinic team has identified several strategies to provide their diverse patient population with access to exceptional care. Some strategies include: <ul style="list-style-type: none"> <li>• Identifying community health services near to a patient's home to eliminate travel time.</li> <li>• Facilitating flexible appointment times to accommodate complicated lives.</li> <li>• Helping non-insured patients access coverage for life-saving drugs.</li> <li>• Helping refugees navigate the claims process.</li> </ul>

	<ul style="list-style-type: none"> <li>• Creating partnerships with other specialties in the hospital such as endocrinology and nephrology, which allow patients to see their specialist in the HIV clinic and greatly facilitates coordination of care.</li> </ul> <p>The 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.</p> <p>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.</p> <p>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.</p>
<p>_____ Geriatric Day Hospital</p>	<p>An outpatient program that provides assessment, treatment and rehabilitation of elderly individuals. Seniors attend the program for a three to five month period. All health professionals in the program have specific expertise in geriatrics and as a team they provide an inter-disciplinary approach in the care of the elderly, dealing with a variety of complex health issues</p>
<p>Communication Skills Training</p>	<p>_____’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 _____.</p> <p>Although not mandatory, Organizational Development provides communication skills workshops throughout the organization. In the coming months, there are plans to adopt the Veterans Centre model for staff in acute and ambulatory care.</p>
<p>Diversity and Inclusion Training</p>	<p>_____’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.</p>
<p><b>Hospital 13: Community</b></p>	
<p>_____ Core Service</p>	<p>In January 2007 _____ rolled out a Core Service Standards program which will be continuing for a third year in</p>

Standards	2009. Each month a different customer service standard is highlighted and staff, physicians and volunteers are provided with reminders and tips on measurable behaviors to meet the standard. Although this initiative is targeted at interactions with all patients, it is hoped that it will reduce barriers for patients and families with diverse backgrounds and care requirements.
Community Advisory Council	One of the ways _____ identifies and targets access barriers is through regular meetings of our Community Advisory Council. This group is consulted with and provides diverse insight on program plans, corporate initiatives, and construction projects. The committee reports directly to the _____ Board of Directors. When recruiting for the CAC the Hospital utilizes existing networks to recruit members of diverse communities.
Diabetes Education Community Network of East Toronto (DECNET)	Established as a partnership with _____ CHC, _____ CHC and this Hospital. The network provides empowering diabetes education aimed at effective self-management, with a focus on 'under-served' 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.
SeniorWise	_____ has been working closely with the National Quality Institute (NQI). Becoming senior friendly helps ensure the hospital is friendly to other groups and populations as well.
Solutions – Healthy Connections 2008 Conference	_____ is a founding member of Solutions – East Toronto's Health Collaborative. The conference provided an excellent opportunity for networking and discussion on health equity.
<b>Hospital 14: Sub-acute</b>	
Rehabilitation for Hemophiliac Patients	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.
Slow Paced Rehabilitation for Chronic/Complex	_____ 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

Disabilities	destinations into sub-optimal housing requiring harm-reduction as a key part of their care plan.
Mental Health/Behaviour Management	Community needs assessments identified individuals living with mental illness and/or cognitive impairment as a priority population. In addition, referrals for individuals with mental illnesses requiring admission for complex continuing care, slow paced rehabilitation and palliative care were increasing. An ensuing improvement was the development of a specialized service for fracture/orthopedic patients with behaviour/cognitive issues and/or mental illness. Behaviour modification approaches, the purchase and installment of a wander-guard system and increasing consultation with CAMH were some of the improvements implemented to meet these patients' needs. Behaviour/history of mental illness is not a barrier to admission at _____ following appropriate risk assessments.
Young Adult Program	Stakeholder engagement with _____ 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 _____ team with the assistance of the _____ [other rehab hospital] team identified the unique requirements for this population and augmented existing services to meet their needs. Implementation of new services for the young adult includes 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 pre-admission patient assessment and as appropriate a pre-booking process for a time-sensitive transition of the young adult. Patients can be accepted for admission upwards of 4 months in advance of their actual transfer. Over 5% of _____'s present complex continuing care census is young adults transitioned from across the continuum.
Hemodialysis Support Program	Patients on hemodialysis (HD) who require slow paced rehabilitation (SPR) following an acute episode and/or surgery have encountered limited access to multi-focused care (i.e. SPR and regular dialysis). 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. Through knowledge exchange and cross-sector teamwork, improvements were implemented 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.
<b>Hospital 15: Rehab</b>	
Research to improve illness prevention and	<ul style="list-style-type: none"> <li>• Identification of needs of disadvantaged: Many projects are underway in this area and include the prevalence of head injuries in women, workers, northern populations and amongst the homeless.</li> </ul>

<p>health promotion for adults with disabilities</p>	<ul style="list-style-type: none"> <li>• Treatment programs to specifically target inequities: For example the identification of bias against aggressive treatment of prostate cancer in older men and treatment of cardiac conditions in women; development of programs for the rehabilitation of older people with hip fractures who have cognitive impairments and have previously not been given an opportunity for rehabilitation. Many people are disadvantaged by their location and as a result of their disabilities not able to attend ongoing rehabilitative care and fitness programs. Several of our research projects have been addressing this through e-health mechanisms, telephone support, rehabilitation integrated community recreational programs and other outreach programs.</li> <li>• 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.</li> </ul>
<p>Heart health and diabetes management in the community</p>	<ul style="list-style-type: none"> <li>• Diabetes management in the community: 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.</li> <li>• HH4L - Heart Health for Life: Each year ~1600 patients from the Cardiac Rehab (CR) Program graduates and now receive a newly designed graduate package which includes certificate, newsletter, new website information, community resource materials and information on local peer support services. This program was created to fulfill the need of the CR graduates for ongoing support and encouragement. There are plans to evolve the program over the next three years to include peer support, connecting with community partners in fitness centres and mall-based walking programs as a means to assist CR graduates to maintain a life-long commitment to their heart health.</li> <li>• Frail elderly and heart health: _____'s CR Program is collaborating with other health care facilities (_____ [community hospital outside TCLHIN] and _____ [critical care hospital in the TCLHIN]) to provide cardiac prevention programs for frail elderly clients in the community.</li> </ul>
<p>Elder care - seniors and fall prevention</p>	<ul style="list-style-type: none"> <li>• Fall prevention among seniors in the community is a focus for the Geriatric Day Hospital and the Stratify Risk Assessment is carried out on all new clients. Public education forums and other free public education is archived on the _____ web site under the Living With and Living Well series.</li> <li>• _____ is also a member of The Hospital Collaborative on Marginalized Populations that highlights elder care/seniors as being an area with health care disparities.</li> <li>• Geriatric Day Hospital has provided outpatient service to clients with debility due to aging and chronic illnesses and serves to help seniors remain as independent as possible in the community. Goal attainment scaling is used to measure the outcomes of care, and there is a formal method of documenting goal attainment.</li> <li>• 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</li> </ul>

	hospital], Long Term Care: _____ Towers and _____ and _____ (Chinese long term care home); and _____ Towers and _____ retirement homes.
Publicly funded outpatient therapy services	<ul style="list-style-type: none"> <li>• Many of the outpatient therapy services grew out of the need to provide follow up rehabilitation after an inpatient episode of care in order to help patients to achieve a higher level of independence in the community. Examples are outpatient therapy for musculoskeletal conditions, spinal cord injury, stroke and acquired brain injury. Many outpatient services are oriented towards providing those with chronic disabilities with illness prevention and health promotion.</li> <li>• 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 (82 and 78 patients respectively).</li> <li>• LIFEspan is a special program in partnership with _____ [other rehab hospital] 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 being provided at this hospital.</li> </ul>
Community fitness programs for chronic disabilities	<ul style="list-style-type: none"> <li>• 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. It began as a joint initiative between Physiotherapy and Therapeutic Recreation. The program has evolved and clinical involvement is on a consult basis only. The program is partially funded through operating dollars and through monthly membership fees for clients. Inpatients become aware of the program through physiotherapy and therapeutic recreation.</li> <li>• The TIME (Together In Movement and Exercise _____) Program partnered with the City of Toronto Parks Forestry and Recreation (subsidized by the City of Toronto) started in 2005 to provide fitness programs for the adults with stroke, Multiple Sclerosis and brain injury. In order to meet the criteria patients must have mobility impairments and be able to walk a minimum of 10 meters with or without a walking aid. Clearance from their family physician is required. 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. Referrals are by word of mouth and family physicians. A simple 1 page flyer was sent to referring institutions, to therapy departments, to the stroke network and to physiatrists to advertise the program.</li> <li>• Exercise DVD helps people with MS stay fit. 4000 have been distributed. The efficacy of the DVD exercise program was tested on 10 subjects in a research trial. Measures of balance and mobility showed improvement.</li> </ul>
<b>Hospital 16: Acute</b>	
Patient-Centered Care (PCC)	During PCC training, staff are coached to be learners and to be curious about the patient's world view rather than assume they know what is important to the patient and family. _____ has also worked on developing

	<p>patient education tools for patients who communicate in languages other than English. For example, meal plans are offered in eight languages and include guidelines on how to manage disease with culturally-preferred foods.</p>
<p>Community Mental Health &amp; Addictions Programs (CMH&amp;A)</p>	<p>_____ is committed to providing health services that meet the medical needs of a linguistic and ethnocultural mix of patients.</p> <ul style="list-style-type: none"> <li>• For instance, the Portuguese Mental Health and Addiction Service provides a range of services to Portuguese speaking clients who have little or no capacity to speak English. The program has multiple partners, such as the Centre for Addictions and Mental Health.</li> <li>• 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.</li> <li>• Housing Support Service focuses on supporting those who speak Spanish and Portuguese and a formal 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.</li> <li>• _____ operates Woman's Own Community Withdrawal Management Services: Patients are supported by trained, female professionals as they go through withdrawal in a safe and comfortable environment.</li> <li>• _____ is also committed to the Toronto Urban Health Alliance program, which provides clinical mental health support to clients of specific community health centres.</li> </ul>
<p>Provincial / Regional Outreach Efforts</p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• <i>The James Bay Project</i> 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.</li> <li>• <i>The Long-Term Care Home (LTCH) Emergency Mobile Nurse Project</i> is an initiative aimed at providing acute geriatric nurse consultation to LTCHs to reduce avoidable ED visits.</li> </ul>
<p>Patient Education</p>	<ul style="list-style-type: none"> <li>• Patient &amp; Family Libraries at _____ offer free multilingual brochure/pamphlet collections for patients, free mini-workshops on how to search the internet for health information and free printing/photocopying of relevant health information. A series of educational workshops, led by Allied Health professionals, address issues on various topics with plain language slides and images to illustrate processes and concepts. We are investigating opportunities to offer the workshops in multiple languages.</li> <li>• The Patient Education Network (PEN) coordinates hundreds of multilingual translation projects of patient</li> </ul>

	<p>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.</p> <ul style="list-style-type: none"> <li>• Health Education Talks partners with Telehealth to videoconference these sessions to remote sites across Ontario.</li> <li>• Community Health provides access to Healthcare in Ontario workshops to newcomers in the community, improved access to oral health and education to lower income residents. This initiative is particularly active with regard to Chinese health education.</li> <li>• Printed Materials: Multilingual print, brochures, posters, Communication Card</li> </ul>
Patient Relations	<p>Patient Relations is an effective advocate for patients and their families. <i>The Virtual Patient Focus Group</i> 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.</p> <p>The department also regularly offers the <i>Patient Relations Road Show</i> attended by over 1000 staff. It offers front-line staff a hands-on, practical approach to patient relations and teaches ways to be responsive to patient needs.</p>
<b>Hospital 17: Rehab and complex continuing care</b>	
TB Non-English Language Services	<p>Of the 100 patients admitted to _____'s TB inpatient unit in 2006, only 16 spoke English as a first language and 37 spoke no English at all. Early assessment of the language needs of these individuals ensures that these patients and their families are provided with professional interpreter services to facilitate effective communication and response to identified care needs.</p> <p>Consistent 98% to 100% rate of completion of TB treatment achieved by _____'s TB Service. This success is sustained through close partnership with Toronto Public Health's Direct Observed Therapy (DOT) Program which monitors patients' compliance and progress in a community setting after discharge.</p>
Supportive Housing Partnership (Rockcliffe-Smythe and Oakwood-Vaughan Neighborhoods)	<p>In September 2008, supportive housing initiatives in the Rockcliffe-Smythe and Oakwood-Vaughan neighborhoods were launched 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. Based on demographics, these individuals typically range in age between 75 and 85 years, are predominantly female, and include a large number of Caribbean, South Asian and Hispanic seniors. Potential clients are identified and assessed using standardized screening and assessment tools by care coordinators to determine eligibility to the appropriate basket of services. _____'s Seniors Mental Health program provides mental health services to eligible seniors on an as needed basis in</p>

	their home environment.
Acquired Brain Injury Behaviour Services (ABIBS) Outreach Program	<p>The 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 to assess the clients' challenging behaviours and to develop a behaviour change plan that is implemented over a 6-9 month timeframe through a series of sessions.</p> <p>A study was conducted to evaluate the impact of _____'s ABIBS Outreach services using measures of symptoms, functioning, quality of life, community integration, psychosocial adjustment, family burden, and individualized measures of goal attainment. 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.</p>
Care Coordinators	Care coordinators act as patient advocates and mediators to assist patients in optimizing their access to relevant health care services from preadmission to post discharge. The care coordinator role is indispensable to facilitating equitable access to health care services for underserved patients.
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.
<b>Hospital 18: Specialty</b>	
Women Only Programs and Women's Health Resources	A number of programs offer services for women-only (e.g. _____ Centre for Birth Control, Brief Psychotherapy Centre for Women, Women's Cardiovascular Health Initiative, _____ Breast Centre, Women's Mental Health Program, etc.) or focus on women's health issues (e.g. _____ Research Institute; _____ Women's Health Information Centre, and Women's Health Matters website). Some programs have incorporated features of feminist mental health counseling models.
_____ Programs Geared to Disadvantaged Populations or Access Barriers	<ul style="list-style-type: none"> <li>• Responding to well-documented disparities in access to abortion care. Longstanding joint initiative between _____ [this hospital], _____ acute hospital and _____ acute hospital.</li> <li>• Responding to very restricted access to health care for people without OHIP coverage: A health card is not a requirement for receiving the above abortion and reproductive health care. Currently, approximately 25% of all _____ Centre for Birth Control patients are uninsured.</li> </ul>

	<ul style="list-style-type: none"> <li>• MOHLTC Designated Anonymous HIV antibody testing Site for women.</li> <li>• Mental Health Services for Women with HIV/AIDS.</li> <li>• The Wellness for Independent Seniors (WISE) Program focuses on the goals of health and wellness for all adults over the age of 60, who live independently in the community.</li> <li>• A variety of research examining issues affecting health care and access to care for lesbian, HIV/AIDS, ethnoracial, immigrant and refugee, disability, uninsured populations etc.</li> </ul>
<p>Joint Programs and Collaborations with Community Partners To Address Needs of Health Disadvantaged Women</p>	<ul style="list-style-type: none"> <li>• Woman 2 Woman Program Initiative with Planned Parenthood of Toronto (PPT): PPT Volunteer peer counselors provide sexual health information for patients at the _____ Centre for Birth Control.</li> <li>• Lesbian and Women who have sex with women (WSW) Health Services: with PPT, Sherbourne Health, Rainbow Health Ontario, Women's Health in Women's Hands, Asian Community AIDS Service and Good for Her to increase knowledge and provision of cervical screening for Lesbian and WSW.</li> <li>• LGBTQ Support Group: for LGBTQ individuals who are parents or would like to become parents: monthly group at Sherbourne Health Centre.</li> <li>• Day Health Program at _____ [other specialty hospital]: a collaboration to develop Women's Case Manager Role to improve health for women with HIV/AIDS.</li> <li>• Women's Health in Women's Hands: providing _____ physician specialist care for Mental Health, HIV/AIDS and Complex Diabetes programming for WHIWH patients.</li> <li>• _____'s Collaborative Task Force on Uninsured and Undocumented Clients: Formed in April 2007, as an initiative of the _____ Women's Health Advisory Committee, to develop a hospital and community health strategy for equitable access to health services for people without health insurance.</li> </ul>