

Table 2c: Promising Practices, summarized, grouped by Hospital type

Complex Continuing Care (Hospitals 1, 3, 9)
Examples of Promising Practice initiatives from Complex Continuing Care Hospitals include:
<ul style="list-style-type: none"> • Specialized Services for Unique and ‘Hard to Serve’ Seniors: specialized programs that prevent older adults from being excluded from the system due to their behaviour, mental health issues and/or cognitive limitations. • 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 • Geriatric Psychiatry Community Services – provides outreach to in-home and outpatient older adults (65+) experiencing psychiatric conditions/mental health issues. • Vocational Rehabilitation Services: The Hospital’s day treatment program offers vocational rehabilitation 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: 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. • Educational Tools for Physicians working with Marginalized Populations: 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. • Patient Advocate: 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 seniors who often find themselves without family and/or friends to act as a champion of their cause. • Senior Support Program – friendly weekly telephone and e-Pal service offered in the language of preference to home-based seniors who are isolated due to health and/or psycho-social issues; 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. • 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. • 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 & Related Disorders, e.g. depression, bipolar mood disorders, bereavement, anxiety, etc.; and Stroke and Cognition, e.g. stroke survivors with cognitive impairment.

- 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; 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.

Rehab (Hospitals 2, 15, 17)

Examples of Promising Practice initiatives from Rehab Hospitals include:

- 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.
- Comprehensive Spasticity Management Clinic: 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.
- 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. Family Advisory Council meets monthly with Board members, the President and CEO and the Vice-President of Programs and Services in attendance.
- Family Support Programs: Financial Support Fund; Onsite Accommodations --ten onsite fully accessible suites are available for parents and caregivers who require overnight accommodation; Interpreter Services; Playroom (onsite free daycare for clients and siblings); The Resource Centre; The Family Relations Coordinator provides information about community resources and develops education sessions to strengthen the family's role as advocates for their child.
- Partnerships and Advocacy around policy changes and systemic improvements that will benefit children with disabilities and their families.
- Telehealth Videoconferencing: In 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.

- Research to improve illness prevention and health promotion for adults with disabilities include: 1) development of programs for the rehabilitation of older people with hip fractures who have cognitive impairments; 2) 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; 3) 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.
- Heart health and diabetes management in the community: Besides 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. To fulfill the need for ongoing support and encouragement for Cardiac Rehab Program graduates, they receive a newsletter, new website information, community resource materials and information on local peer support services. 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.
- 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. 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 are archived on the hospital's web site.
- 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. This rehab hospital partners with an acute hospital, long term care homes including a Chinese home, and retirement homes.
- Publicly funded outpatient therapy services: 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.
- 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

- LIFEspan is a special program in partnership with another 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.
- Community fitness programs for chronic disabilities: 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. The program is partially funded through operating dollars and through monthly membership fees for clients.
- 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. The need for this program was determined from feedback of inpatients.
- Exercise DVD helps people with MS stay fit. The efficacy of the DVD exercise program was tested on 10 subjects in a research trial. Measures of balance and mobility showed improvement.
- Supportive Housing Partnerships in neighborhoods were launched through a partnership between the Seniors Mental Health program at the hospital and five to six other organizations. Service is provided, in a cluster care arrangement, to eligible seniors living in targeted apartment buildings. 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.

Specialty (Hospitals 5, 6, 18)

Examples of Promising Practice initiatives from the Specialty hospitals:

- 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.
- Women's Case Manager: 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 specialty 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 are to be offered in the Day Health Program.

- Sherbourne Health Bus: 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: active in the TCPI Special Housing Working Group to further meet the needs of Toronto's HIV/AIDS hard to house population.
- Visiting Dietician Program: nutritional therapy post-discharge for highly specialized paediatric nutritional care in the community is required but seldom available. 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.
- Neonatal Intensive Care Unit Research Study: 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.
- Pro Bono Lawyer Program: part of a partnership with Pro Bono Law Ontario will see the introduction spring, 2009, 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.
- 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; 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; 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. 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.

- Programs Geared to Disadvantaged Populations or Access Barriers [for women]: Responding to well-documented disparities in access to abortion care; restricted access to health care for people without OHIP coverage; Designated Anonymous HIV antibody testing Site for women; Mental Health Services for Women with HIV/AIDS; 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; care for lesbian, HIV/AIDS, ethnoracial, immigrant and refugee, disability, uninsured populations etc.
- Joint Programs and Collaborations with Community Partners To Address Needs of Health Disadvantaged Women: Woman 2 Woman Program Initiative with Planned Parenthood of Toronto (PPT); 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.
- Day Health Program at _____ [other specialty hospital]: a collaboration to develop Women's Case Manager Role to improve health for women with HIV/AIDS.
- Women's Health in Women's Hands: providing _____ physician specialist care for Mental Health, HIV/AIDS and Complex Diabetes programming for WHIWH patients.
- _____'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.

Acute (Hospitals 7, 11, 16)

- Gateways to Cancer Screening: A Participatory Needs Assessment of Women with Mobility Disabilities: 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 & people with disabilities, as well as architectural, attitudinal, socioeconomic barriers.
- Talk to Me: Violence Against Women Awareness Program: 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.
- Association for the Advancement of Blacks in Health Sciences Summer Mentorship Program: 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.

- 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).
- Central Access Withdrawal Management Service: _____ administers a Central Access telephone triage and service matching program with the other Withdrawal Management Services [at three other hospitals in the TCLHIN].
- My Baby and Me Passport Incentive Program: 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.
- Homeless Balanced Scorecard: 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.
- Rotary Transition Centre and Emergency Dept. Community Worker: Transition Centre provides a temporary safe, welcoming and hospitable 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. 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: 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.
- Patient-Centered Care (PCC): In 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 patient education tools for patients who communicate in languages other than English.

- Community Mental Health & Addictions Programs (CMH&A): committed to providing health services that meet the medical needs of a linguistic and ethnocultural mix of patients. The program has multiple partners, such as the Centre for Addictions and Mental Health; member of the Chinese Mental Health Network; member of the Early Intervention in Psychosis Network. The programs include: Housing Support Service; 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; Woman's Own Community Withdrawal Management Services; committed to the Toronto Urban Health Alliance program, which provides clinical mental health support to clients of specific community health centres.
- Provincial / Regional Outreach Efforts: 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.
- 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 Long-Term Care Home (LTCH) Emergency Mobile Nurse Project is an initiative aimed at providing acute geriatric nurse consultation to LTCHs to reduce avoidable ED visits.
- The Patient Education Network coordinates hundreds of multilingual translation projects of patient education materials each year, while providing training to clinicians on plain language and health literacy. Features the "teach back" method, an important approach for patients with limited English proficiency, low health literacy or cognitive limitations.
- Health Education Talks partners with Telehealth to videoconference these sessions to remote sites across Ontario.
- 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.
- Patient Relations Road Show 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.
- 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.

Sub-Acute (Hospitals 8, 14)

- 'Flo Collaborative' with _____ acute care 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, 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.
- The Tamil Caregiver Project provides support, recognition of their difficulties, education and information about access to health care services. On request, trained Tamil/Saivite/Hindu spiritual workers visit Tamil individuals in partnering hospitals and long-term care homes.
- Low-tolerance Stroke Rehabilitation Program: 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: 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.
- 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 Disabilities: identified the need for increased access to slow-paced rehabilitation for individuals presenting with multiple co-morbidities, chronic disability, and/or socioeconomic challenges. 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.

- 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 _____ [this hospital] 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.

- Mental Health & Addictions Shared Care Programs: 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.
- Mental Health Mobile Crisis Team: 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.
- Family Medicine Centre + Family Health Team: 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. 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.
- The Elderly Community Health Services (ECHS): 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.
- The Toronto Centre for Substance Use and Pregnancy T-CUP: 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.
- Core Service Standards: 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: 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-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.

- SeniorWise: 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: Solutions – East Toronto’s Health Collaborative. The conference provided an excellent opportunity for networking and discussion on health equity.

Critical Care (Hospital 12)

- 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: several strategies to provide their diverse patient population with access to exceptional care including: Identifying community health services near to a patient’s home to eliminate travel time; Facilitating flexible appointment times to accommodate complicated lives; Helping non-insured patients access coverage for life-saving drugs; Helping refugees navigate the claims process; 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; 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. 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.
- Geriatric Day Hospital: 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.

- **Communication Skills Training:** 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 _____.
- **Diversity and Inclusion Training:** 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.

Specialized Clinical Care (Hospital 4)

- **Population-specific addiction programs developed to address underserved populations:** LBGTTQQII, Portuguese-speaking, African Canadian youth, Spanish-speaking, women, aboriginal people, heroin users.
- **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. This service provides in-service sessions to outpatient (including satellite clinics) and inpatient staff on how to work with interpreters.
- **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.
- **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:

- The Development of a Problem Gambling Screening Instrument for Older Patients
- The Experience of Families of People with Developmental Disabilities in Crisis.
- Assessment of Mental Health Needs of the Thai Population in Ontario
- Mental Health Experiences of Government Assisted Refugees
- Transnational Research on Refugee Youth Coping Strategies
- Prescription Opioid Injection Among Street Drug Users in Toronto
- Creating Links Through Research
- Bisexuality, Mental Health and Emotional Well Being in Ontario
- Provincial Services: Engages local communities to advance best and promising practices throughout the health continuum. Examples:
 - Introduction to Diversity: Training to increase diversity awareness and improve cultural competency for service providers
 - 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
 - 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
 - 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.
- Health Promotion Initiatives that address Social Determinants of Health:
 - 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.
 - Youth -Strengthening Families: Skills development program designed to reduce risk factors & enhance protective factors of children age 7-11 whose parents have a history of alcohol & 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
- Published resources:
 - 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.
- Working with Immigrant Women: Issues and Strategies for Mental Health Professionals.
- Homeless and Street Involved People Housing Guide 2004-2006: A Comprehensive Guide for People with Mental Health and Addiction Concerns
- Education Services: 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.
- Diversity related educational events/projects (external):
 - Provincial Intro to Diversity & “ARQ2” trainings (started 2002-2003)
 - “Mental Health and Addiction 101” series (launched 2008)