APPENDIX 4:

LIST OF 'TRAVEL WELL' INITIATIVES

The following list was compiled from Hospital responses to the following item from the template:

"Tell us more about one initiative directed towards addressing a crucial access barrier or improving services and quality for a particular disadvantaged population that has been especially effective and/or innovative, and that may have wider implications for other hospitals. In other words, look for initiatives that could be particularly useful to pass on to other hospitals – that can 'travel well'."

Hospital's Concurrent Disorders Service formed a partnership with community provider, the Toronto Aboriginal Care Team at the Native Child and Family Service, to improve access to care and outcomes of Aboriginal people who are experiencing mental health and addiction difficulties. Staff at both agencies developed a model of care that is shared, integrated and culturally sensitive; uses client-centred approach, biopsychosocial assessment practice; has reduced previously existing barriers such as clients' aversive experiences with hospital context, psychiatrists, discrimination; has been successful and other departments seeking consultation.
Interprofessional prevention of delirium (IPPOD) is a knowledge translation strategy in place since 2007 that includes interactive workshops and online tools that teaches physicians, nurses, psychologists, security guards, paramedics and volunteers how to prevent delirium so that EDs can operate more efficiently. One quarter of elderly patients are at risk of developing delirium during their hospital stay, and research shows that delirium prolongs stay by as much as 58 days. Also, Hospital designed a toolkit EnTICE (Enabling Teamwork, Interprofessional Collaboration and Education) to help front-line healthcare workers introduce best practices into their clinical setting more effectively. IPPOD has been tested out in Hospital's ED since 2007 and now being rolled out hospital-wide; the online tools are easily accessible for other EDs.
Pilot program that addresses youth and mental illness in a school-based program with onsite psychiatrist, social worker, and child & youth worker training educators and treating youth depression with psychotherapy within the school setting. The program provides a model of care that has the potential to be exported to other schools in GTA and beyond, and similar initiatives have been effective in the USA.
The "3Ws and an H" tool, developed collaboratively by Patient Education Programs jointly at two Hospitals provides a framework through which Health Care Providers can condense their clinical knowledge into specific actionable information for patients and families in plain language. The title of the tool refers to Who (are you writing for?), Why (should they read it?), What (do they have to do?) and How (is it written?). "This tool allows developers to look at their audience more closely and address specific needs, including font size, literacy level, plain language, translation, pictures, use of white space, etc., making it a good demonstration of how equity principles can be incorporated into daily operations."
Building access and equity for Ontario's Trans Communities: Collaboration with Trans Community and Sherbourne Health Centre: 10 years after Sex Reassignment Surgery (SRS) was delisted for trans people in Ontario, it was added back for OHIP coverage in 2008, but access to publicly funded SRS would require approval by a specified clinic at this Hospital. The Trans community was concerned that the standards for approval were interpreted very conservatively and meant that potential candidates who might otherwise be eligible were deemed ineligible by the clinic; also the service at the Hospital had previously been regarded as not sensitive, respectful or supportive of clients' needs. Hospital initiated discussions with the Trans community members and Sherbourne HC. In 2008 then Minister George Smitherman wrote to President and CEO of Hospital and the CEO of Sherbourne HC to seek their advice on the standards of care that the MOHLTC should consider with implementing relisting of SRS.

Hospital, Sherbourne HC and Rainbow Health Ontario (a provincial LGBT capacity-building program based at SHC), jointly organized, with several leaders in the trans community, a policy forum for the presentation and discussion of SRS and trans health policy options in Feb. 2009. Following the forum, Dr. Steini Brown asked the group to submit recommendations and a Terms of Reference for a Steering Committee. The Ministry has now committed to bringing forward several initiatives to improve access to needed services for trans people in Ontario and increased service capacity in health care providers. Travel well lessons from this initiative: "Importance of proactive community engagement; Need to be flexible and responsive in terms of hospital services; Power of the hospital community partnerships; Importance of involving senior hospital staff in such partnerships."

Hospital engaged in a community-based participatory action research project with participants who identified themselves as living with a mobility disability, shared their experiences with cancer screening (breast, cervical and colorectal) and made recommendations to improve their access to preventative care. The project's initial phase identified barriers such as physical access, lack of knowledge among the women, neglect by health care providers and inflexible transportation. Age and English proficiency were also factors. Attitudinal barriers were as much to blame as architectural ones, the study found.

The Hospital then partnered with Toronto Public Health and South Riverdale CHC to produce *Engaging Seldom or Never Screened Women in Cancer Screening: A Compendium of Pan-Canadian Best and Promising Practices*. The electronic version of this compendium has been downloaded by approximately 500 agencies across Canada and internationally. An extensive knowledge exchange process is in effect along with an evaluation component exploring the service provider's plans to use this compendium for program planning, networking and research collaboration.

The project has already resulted in changes. Hospital now has mammogram machines that enable the patient to remain seated. Renovations are beginning to create accessible change rooms in the Breast Centre, and the Medical Imaging department books several diagnostic tests on the same day for patients with disabilities to address challenges with transportation. Although this current project focuses on breast cancer screening Hospital believes it could be adapted for many health services.

Travel well aspects: "Engaging in participatory processes with patients and community partners to create greater access to services; How to leverage the findings from research and the relationships developed through the process into projects that facilitate access to service; Communication and knowledge transfer strategies to encourage and support other hospitals to increase access to services; The ways in which the partners built sustainability into the project by adding to it phase by phase."

Hospital secured a financial contribution from Citizenship and Immigration Canada in 4/2009 towards the establishment of the New Immigrant Support Network (NISN) at the Hospital which aims to improve access to health care and health information for new immigrant children and their families; benefits extend also to racialized groups and those with limited English. Some key initiatives undertaken by the NISN that have been "especially effective and innovative" and would have wider implications for other hospitals and the broader health community, include: 1) Cultural Competence Education Program: half-day workshops for non-clinical staff and one or two-day workshops on clinical cultural competence. Preliminary evaluation findings demonstrate that health providers are translating knowledge gained through the workshops in their practice to enhance equitable access to care; requests for interpreter services has increased because of this education; clinicians have a greater awareness of personal bias and the role it plays in healthcare provider-patient/family relationships; clinicians are also expressing a greater comfort level asking questions related to culture and health beliefs and using cultural assessment tools as part their overall clinical assessment. 14 short e-learning modules and a film on cultural competence have been created. 2) Translation of Patient Education Materials: translation of extensive patient education materials -- 300+ patient education materials, appointment cards and letters, consent forms, etc. -- into up to 9 languages; available to staff and patients/families in Fall 2010 in both printed and audio file forms. The Hospital's website is also being translated into French and simplified Chinese. 3) Cultural Competence Champions Program: to build capacity and sustainability, approximately 100 Champions have been identified across the Hospital to act as change agents and to promote the delivery of culturally competent care. 4) Multi-lingual Information Kiosks: 8 touch-screen computerized kiosks in 10 languages with information about hospital services, maps/directions, link to website will be placed in strategic locations throughout the hospital. 5) Enhanced

Utilization of Interpreter Services: although a telephonic interpreter service is available, this is not well utilized, primarily because of a lack of awareness of the service and equipment and logistics issues. To address equipment and logistics issues, 45 special telephones (designed specifically for telephonic interpretation) have been procured for all patient care areas for short interactions and use during evenings and weekends. 6) Case Management Pilot: a pilot to test an intensive case management service delivery model for new immigrant children/families to better understand their needs, determine the types of interventions that are most effective has provided a good understanding of what a future case management service should entail; evaluation results clearly demonstrate the benefits to a newcomer with a child with a complex illness. 7) Policies and Procedures: key policies and procedures (e.g., death and bereavement) are being examined to ensure that respect for diversity of cultural and religious values/practices is integrated.

Emergency Department Newcomer Navigational Video provides patients with information on what they can expect when coming to the ED, available in the top six languages: Cantonese, Mandarin, Portuguese, Spanish, Tibetan, and English. Travel well aspects: "The video messaging is generic enough that it can be beneficial to newcomers using other hospital Emergency Departments throughout the province. The video has been distributed free of charge to community agencies and to date has been shared with over 50 agency contacts, and is easily accessible on the hospital website …"

English as a Second Language Hospital Volunteer Training Program: This program, in partnership with the Toronto Catholic District School Board, is unique; the only program of its kind in Canada. It is designed to support new immigrants who are pursuing a career in health care or an entry-level position in a healthcare setting. Most students have been in Canada for less than 2 years and come from Asia, South America, Europe, Africa and the Middle East. This program addresses the dual needs of new immigrants to develop proficiency in the English language and to obtain Canadian experience, while supporting them to successfully enter healthcare professions; many anticipated to be in short supply in the future.

This program focuses on teaching general medical terminology to non-native English speakers and prepares students for future qualifying professional exams. Over the four month program students attend full time ESL classes and are given an opportunity to volunteer at the Hospital to gain hands-on Canadian experience and an opportunity to interact with both patients and hospital staff. Basic First Aid (CPR) is also offered as part of the program so many of the students obtain this certification.

Implemented nearly a decade ago, the program has now graduated 400 students and has a graduating success rate of over 90 per cent.

Hospital has recruited a number of graduates from the program for employment in the hospital's Emergency and Complex Continuing Care Departments and the Laboratory. The program is now additionally supported by a bursary program funded by the Volunteer Services Association. Each session, three students are provided with funds to assist them with their professional qualifying exams.

The Hospital's Community Advisory Panel identified access to health services for people without health insurance as an urgent community health concern for the GTA. A Collaborative Task Force was formed in 2007 to study access to services for uninsured and undocumented people. As the Network members identified the systemic and programmatic barriers, and policy and health-care access needs for this community of patients, it became evident that there was a dearth of evidence and research to draw on towards building responsive health equity and access strategies. This was due largely to the precarious location of individuals in this population. In response, the Network partnered with Wellesley Institute, Lawrence S. Bloomberg Faculty of Nursing at University of Toronto and the Institute for Health Research at York University, and hosted in February 2010 the first-ever Research Conference on Healthcare for the Undocumented and Uninsured. The conference identified the most vulnerable groups, analyzed the harmful impact on their health of being denied access, and set out organizational and policy directions to address these barriers. The research findings and recommendations from the conference were made available to the public and the Network is currently working with members from the Hospital Collaborative for Marginalized Populations and the Community Health Centre sector to develop common strategies that hospitals can implement to improve access to care for this population. Additionally, the Network is working with the Wellesley Institute to advance policy recommendations that can influence system-wide operational changes and

systemic policy changes.

The Network itself also continues to serve as a resource for hospital and community health-care providers seeking to access responsive care for clients who are undocumented, uninsured and without the ability to pay for their care. Additionally, the research and expertise of the Network is currently being used by the Hospital Collaborative on Marginalized Populations to inform development of community partnerships and internal procedures and protocols.

Hospital embraced 'LEAN thinking' as a method for continuous improvement and employee engagement. LEAN is helping the Hospital solve important challenges, such as patient flow, by identifying and eliminating non-value-added activity and then making changes for the better. Several 'Rapid Improvement Events' have been held in the past 18 months that were designed to address barriers to providing effective service in the following areas: Wait List Management; The Bed Turn Process; Transferring the Patient Chart between units; Creating Capacity to Prevent Falls

For the fiscal year ending March 31, 2010, Hospital admitted more people (from 1749 to 1905) and sent more people home (over 73 per cent, an improvement of 5 per cent over the previous year).

Hospital is tightening the connections between acute care, post-acute care and community sector partners. Since the post-acute sector provides care for the highest risk frail elderly, and because Hospital's workspace is between acute care and the community, Hospital has taken a leadership role in facilitating linkages to improve patient flow.

Travel well aspects: "This proven model – the 'Sector Linkage Model' - can be replicated throughout the province, is self-sustaining after initial investments are made, and can be done with existing budgeted funds.

Clinical data can now be used to track patients as they move through an episode of care from acute care back to home, to monitor system effectiveness and efficiency. Furthermore, optimizing flow and care along an episode of care in this way would be supported by the proposed Health Based Allocation Model of funding.

The Sector Linkage Model involves having staff from each sector move upstream into partner organizations within a region to more rapidly assess and begin to manage patients. For example, currently victims of stroke requiring rehabilitation in Ontario wait on average over 30 days to start this aspect of their care… it should be 7 days.

Missing this window of opportunity results in slower, costlier recovery, with poorer long term outcomes. These people wait in the most expensive beds in the system and ultimately cost the system even more because of their preventable long term disabilities.

Once the patient reaches the post-acute facility, the model dictates care based less on the disease process, and more on the person's needs. With a focus on a person's needs, there is a greater chance that the person can be directed to home and away from institutionalization. Ultimately home is where individuals want to be, and home tends to be the least expensive, and safest option.

Navigation is another critical component of the Sector Linkage Model. … Our Navigators have demonstrated that providing telephone support improves satisfaction, improves clinical outcomes and prevents readmissions to acute care.

The Sector Linkage Model is predicated on shifting resources from inpatient care to outpatient /ambulatory care. The growth in outpatient / ambulatory care is essential and cost-effective, demonstrating significant value for money. Connections with community physicians are required to complete the continuum of care. As the age, and complexity of our / their patients increase, we need to be able to support physicians in their ability to support patients in their homes for longer periods of time."

Hospital's mandate in its values, mission, vision, translated to initiatives that address barriers to access to Complex Continuing Care and/or Palliative Care such as waiving of co-payment during rehabilitation, health insurance not an admission barrier, housing not an admission criterion, need for management of acute behavioural and/or mental health issues.

The New Heights CHC Seniors Health Project (SHP) is a collaborative model of primary care which facilitates in-home health care and social services for vulnerable homebound seniors in the Englemount-Lawrence Community. The objectives of SHP are: 1) To provide primary care services and access to specialized services (e.g. Hospital Geriatric and Psychogeriatric Outreach teams) to frail, at-risk and marginalized seniors who have difficulty accessing primary care; 2)To reduce inappropriate admissions to Emergency Departments and inpatient units and provide the necessary support; 3) To provide ongoing linkage to other support services such as existing CDC services (e.g. Forever Young, Diabetes Education Centre), community nursing support (Toronto Central CCAC) and community support services (e.g. St. Clair West, Circle of Care, Downsview Support Services).

In co ordinance with and funded by Ontario's Aging at Home Strategy, the New Heights CSC SHP is in early stages of evaluation, however key indicators at a glance demonstrate positive results:

- A total of 97 new clients were referred to the program; the top three referral sources include New Heights CHC (33%), CCAC (21%), and Community Referrals (11%);
- All clients were above 65 years of age;
- All clients were without a family physician linked to primary care;
- 93% of clients were satisfied with the program;
- All clients were served in their own language;
- 28% of clients were admitted to the program from acute care inpatient units;
- 30% of clients were discharged per quarter.

A Hospital Communications Disorders Assistant developed 'Communication Boards' that are available for use by staff, patients and families in English, and have now been translated into nine other languages (French, Arabic, Spanish, Traditional and Simplified Chinese, Punjabi, Tamil, Urdu and Portuguese, as per Citizenship and Immigration Canada guidelines). These Boards are an innovative and potentially transferable tool for use with patients in hospitals and health care settings who have a variety of communication challenges (e.g. aphasia, apraxia, dysarthria). They were developed using best practices and adapting existing tools from a variety of sources. Examples of topics covered by these boards are: Medication, Eating Preferences, Feelings and Discharge Plans.

The tool uses illustrations and plain language to reach a more vulnerable population of patients whose ability to communicate is impacted by such medical conditions as stroke, ALS, Huntington's, head injuries and/or or their level of literacy and comprehension of the English language.

Travel well aspect: "We feel it would be of tremendous value to have this resource produced, disseminated and more widely distributed to other health care facilities for use with patients who do not speak English, as well as for English speaking patients with speech/language/communication disorders."

In the past Hospital has been challenged to meet the needs of confused seniors at risk for wandering away. Admission of these patients was low. In order to address this issue, Hospital installed and initiated a patient wandering prevention system throughout the hospital. A procedure was developed to assess the wandering behaviours of existing and newly admitted patients and to adopt the use of this system with patients who would benefit. All clinical staff were trained in the use of the wandering prevention system. This has allowed Hospital to increase the admission of seniors at risk for wandering.

The Code Yellow procedure was updated to require online incident reporting, which allows better monitoring of data regarding patients who wander away. Anecdotal evidence suggests that the organization commonly had 2 to 3 Code Yellow incidents per year prior to the above changes. Since the transition to the new facility 11 months ago and utilizing the wandering prevention system, there has not been a single Code Yellow incident.

In late 2008, a supportive housing partnership (Rockcliffe-Smythe and Oakwood-Vaughan neighborhoods) was launched as part of the Aging at Home Strategy through a partnership between the Seniors Mental Health Service at Hospital and six other organizations.

This initiative involves the provision of services 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.

As part of this partnership, Hospital's Seniors Mental Health Service provides specialized mental health services to eligible seniors on an as needed basis in their home environment.

This initiative mitigates barriers associated with aging, poverty, illiteracy, language, ethnicity, physical disabilities, sub-standard living arrangements, and/or mental health disorders.

Clients with communication disorders waiting for services to acquire the needed technology for Augmentative Communications Services (ACS), which requires highly skilled clinicians with expertise in augmentative communication systems in order to address clients' complicated communication needs, waited up to 24 months for a first appointment. "A review of the service revealed that the model was extremely cumbersome with 14 clinical teams providing services across four geographically dispersed regions. Each team managed its own wait list resulting in inequity across the four regions. As a result, ACS introduced the following strategies to reduce wait times and improve equity and access to care.

- Created a centralized waitlist where referrals are addressed in the order in which they are received.
- Set productivity targets for clinicians
- Identified team leaders to monitor wait times and targets. As of March 2010, 90% of clients were seen within 8.5 months, with an average period of wait of 6 months. This strategy provides leadership and accountability for addressing wait times
- Streamlined the referral process so that clients who do not meet service criteria do not wait unnecessarily on multiple waiting lists.
- Revised referral criteria to ensure it is clear, easy to understand and equitably applied. The team has also removed the need for a medical referral which has enhanced access to care for individuals who do not have a family physician or pediatrician.

The team is building capacity with community partners so that clients can receive services closer to home. From 2007 to 2010, 235 referrals were redirected to other clinics. ACS has formed meaningful partnerships and helped build capacity in other regions to address client needs effectively and closer to home.

The LIFEspan Service is a partnership with a Rehab Hospital. LIFEspan addresses the needs of people with childhood-onset disabilities (currently cerebral palsy and acquired brain injury) as they transition from pediatric to adult care and through their adult lives. … This service continues to build system capacity by developing partnerships in the community and looking for opportunities to expand its reach. Funding for a four-year study to evaluate the LIFEspan model was attained in 2008 through the Ontario Neurotrauma Foundation. A proposal to expand the LIFEspan Service to include services for individuals with spina bifida, childhood acquired spinal cord injury and neuromuscular conditions such as Duchenne muscular dystrophy was submitted to the TC LHIN in November 2009.

In 2009, Hospital and PASAN (Prisoners with AIDS Support Action Network) hired a Harm Reduction Professional Development Consultant to support staff to operationalize the recently introduced Harm Reduction policy and philosophy within the residential and community program. The consultant focused on capacity building within the clinical team to support positive client outcomes, drawing on knowledge of substance use, harm reduction, HIV/AIDS, criminal justice, health, anti-oppression philosophy and social services. In 2010 the Hospital seconded a PASAN staff member with experience in harm reduction to work in a social work role fulltime for one year in order to integrate psycho-social assessment and treatment within a Harm Reduction framework linked with outcomes specific to Harm Reduction including: a) Facilitating Harm Reduction rounds every two weeks, encouraging participants, leading discussions, facilitating process and informal teaching/education and mentoring of staff members; b) Consult, mentor and support clinical staff to identify harm reduction client issues, develop treatment strategies and goals, with a focus on increasing staff capacity in Harm Reduction philosophy; c) Assist clinical staff to increase their awareness of and develop relationships with community based Harm Reduction services and programs with which to link Hospital clients; d) Actively identify and participate in programmatic shifts as they relate to Harm Reduction policy and practice which reflect changing client needs, service demands.