Catholic Health Care in Ontario

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A CALL TO SERVE: SERVING THE MARGINALIZED and VULNERABLE

A CALL TO SERVE: SERVING THE MARGINALIZED and VULNERABLE

EXECUTIVE SUMMARY

INTRODUCTION:

"The Church does not wait for the wounded to knock on her doors, she looks for them on the street, she gathers them in, she embraces them, she takes care of them, she makes them feel loved" *(Pope Francis- "The name of God is Mercy"; Random House, New York, 2016)*

"Catholic Health care begins with a deep respect for the intrinsic value and dignity of every human being and an unwavering commitment to serving all people from all backgrounds and faiths - especially society's most vulnerable.

Catholic health organizations take a holistic and compassionate approach, recognizing the whole person in community and the diverse cultural and spiritual needs of the people we serve. Our mission-driven organizations foster a culture where those involved in the healing journey are people first - where care providers participate with those they serve with compassion and humanity." (Principles of Integration; CHAO, October 2016.)

THE CALL TO SERVE THE MOST NEEDY AND MARGINALIZED IN SOCIETY IS THE HALLMARK OF CATHOLIC HEALTH CARE WHICH MOTIVATED OUR FOUNDERS OVER 350 YEARS AGO.

As members of the Catholic Health Association of Ontario, we need to remain true to this legacy by encouraging the collaborators in our facilities to make the needs of those most vulnerable an integral part of our Catholic works.

The CHAO in conjunction with the Catholic Health sponsors for Ontario has, as it's priority, undertaken a survey of all Catholic facilities in Ontario to determine the extent of this legacy, document the programs and/or services offered in our facilities and share this information across all sponsor organizations. Catholic Health International provided leadership in producing the document which is endorsed by the Sponsors of Ontario and the CHAO Board.

The Catholic Health Alliance of Ontario is made up of the four Catholic Sponsors operating in Ontario, namely: Catholic Health International (CHI); Catholic Health Sponsors of Ontario (CHSO); St. Joseph's Health Society, London; and St. Joseph's Health System, Hamilton, who are members of CHAO. The CHAO acts as a Secretariat to this group to facilitate work of mutual interest and to speak as a unified voice for Catholic healthcare in Ontario.

The intent of this document is to share the programs and services our members are providing to carry out Catholic works in serving the marginalized and vulnerable. Members are encouraged to review these programs, contact the organizations and expand their horizons to implement similar programs/services to meet an unmet need in their community.

ORGANIZATION: Bruyère Continuing Care Ottawa

SPONSOR: CHSO

PROGRAM: Orleans Family Health Hub

Program Lead: Amy Porteous VP ,Planning, Public Affairs and Family Medicine aporteous@bruyere.org, 613-562-6262,Ext. 4040

Year Program Started: Fall 2007

Target Population: People aged 65+,outpatients

Community Partners/Agencies: Monfort Hospital, the Children's Hospital of Eastern Ontario, the Champlain Community Care Access Centre, Ottawa Public Health, Youth Services Bureau and the Eastern Ontario Resource Centre

Impacted (intended or actual): Outpatient clinics, care will be provided closer to home

INITATIVE

Orleans Family Health Hub:

Another partnership that Bruyère has been actively involved in is the development of the Orleans Family Health Hub. This is a unique partnership designed to create an integrated, high-performing, client-centered organization to residents of Orleans and eastern Ottawa with complex or multiple interrelated conditions or who want more accessible services closer to home. Partners include Montfort Hospital, the Children's Hospital of Eastern Ontario, the Champlain Community Access Centre, Ottawa Public Health and many more. Bruyère was a key member of the steering committee and several working groups with the aim to submit to the Ministry of Health and Long-Term Care (MOHLTC) the second phase of the capital submission. Bruyère involvement will be in the areas of geriatrics and rehabilitation. The Phase 2 submission was accepted by the MOHLTC, and we are now waiting for more details on Phase 3 planning.

ORGANIZATION: Mattawa Hospital

Sponsor: CHSO

PROGRAM:

Program Lead: Ben Holst

Year Program Started: 2005

Target Population: Individuals living with serious and persistent mental illness in East Nipissing and individuals experiencing Crisis

Community Partners/Agencies: EN Crisis Intervention, Mattawa Psychiatry, CMHA, PEP, Community Counselling, Centre of Nipissing, Mattawa, Women's Resource Centre, physicians from the Mattawa Medical Clinic

Impacted (intended or actual): Access to case mgmt. services, referral and advocacy to other services as needed

INITATIVE

Mental health service collaboration with other health service providers

ORGANIZATION: Bruyère Continuing Care Ottawa

Sponsor: CHSO

Program: Syrian Refugee Program

Program Lead: Debbie MacGregor, Director, Family Medicine, DI and CDSM dmcgregor@bruyere.org 613-562-6262, Ext. 1432

Year Program Started: Jan 14- May 26, 2016

Target Population: Syrian refugees arriving in Canada

Community Partners/Agencies: Refugee 613

Impacted (intended or actual): High number of refugees received primary health assessments and care coordination provided upon arrival in Canada

INITATIVE

Syrian Refugee Program:

Bruyère's Family Health Team (FHT) took a leading role in the settlement of Syrian refugees in Ottawa. Special clinics were held to provide immunizations and other services to refugee families. A total of 104 new patients have been accepted into the FHT primary care practice.

The Bruyère Family Health Team takes to heart the fact that its mission is to care for the most frail and vulnerable in our society. As such, when looking to expand their services in our catchment area, a natural fit was to provide medical support to the Ottawa Mission Hospice. As mentioned earlier in the welcoming of Syrian refugees making Ottawa home, the FHT provides initial assessments and support to newcomers and are often their first exposure to the Canadian health care system.

ORGANIZATION: Mattawa Hospital

Sponsor: CHSO

Program:

Year Program Started: 2007

Target Population: Rural, isolated, francophone patients

Community Partners/Agencies: Hospital in Temiskaming

Impacted (intended or actual): Improve health condition, disease management for isolated community members

INITATIVE
Thorne Clinic (isolated community)

ORGANIZATION: Mattawa Hospital

Sponsor: CHSO

Program:

Program Lead: Tanya Bélanger

Year Program Started: 2012

Target Population: Unattached patients in the Mattawa Area

Community Partners/Agencies: The physicians from the Mattawa Medical Clinic

Impacted (intended or actual): Improve access to primary health care for unattached patients

INITATIVE

Primary Care Clinic for those with no primary provider

ORGANIZATION: Providence Care, Kingston

Sponsor: CHSO

Program: Providence Village: Addictions and Mental Health Redesign, Hospice Kingston EXTRA Project

Program Lead:

Year Program Started:

Target Population:

Community Partners/Agencies:

Impacted (intended or actual):

INITATIVE

Providence Village:

Providence Care and the Sisters of Providence of St. Vincent de Paul last year announced an intention to partner on a new project called "Providence Village." Over the past 12 months, our two leadership teams have formed a steering committee to complete a Master Program and Master Plan for 30-acres of land currently owned and occupied by the Sisters.

The Providence Village concept includes co-locating Providence Care's redeveloped long-term care home, a residential hospice and accommodation for the Sisters on the property. Additionally, the committee is considering other housing and service options that would form the basis of a neighbourhood that fosters wellness and hope. Although still in the early stages, Providence Village represents a new and continuing commitment for Providence Care during a time when the Sisters of Providence are looking to the future and determining how to ensure their Vision to work toward a world where the vulnerable experience compassion, justice and peace.

Addictions and Mental Health Redesign:

Providence Care is working collaboratively with the South East LHIN and other mental health and addictions service providers in our region to improve access to mental health services outside of the hospital setting. Providence Care is part of the South East Addictions and Mental Health (AMH} Strategic Alliance, and is contributing its expertise as a provider of both specialty hospital and specialty community-based programming. For several years, our teams have worked in cooperation with other agencies; this work takes next steps and has led to the LHIN establishing three bodies to coordinate services in the eastern, central and western regions of southeastern Ontario. As the system-level redesign continues, Providence Care is ensuring our focus remains on supporting clients and their families through the change and providing high quality care within available resources.

Hospice Kingston:

Over the past two years, Hospice Kingston and Providence Care have begun working more closely together with the shared vision to increase access and options to patients and families seeking palliative care. The partnership includes plans to locate a new residential hospice on the future site of Providence Village.

EXTRA Project:

A Kingston team made up of representatives from Providence Care, Kingston General Hospital and the South East Community Care Access Center will soon begin work to improve access to palliative care services for patients in southeastern Ontario.

The team is one of 10 from across the country chosen in April 2016 to participate in the Canadian Foundation for Healthcare Improvement's (CFHI) 2016-17 EXTRA Program. For more than a decade, the EXTRA program has supported 338 healthcare professionals from 134 organizations who have undertaken 211 healthcare improvement projects.

Over the next 14 months the Kingston team will work to establish a centralized intake system for patients who require palliative care services. The aim is to improve access to this important clinical support for patients with a life-limiting illness.

ORGANIZATION: Providence Healthcare, Toronto

Sponsor: CHSO

Program: One Client One Team Stroke Pathway

Program Lead: Maggie Bruneau, VP Partnerships and CNE 416-285-3666, Ext. 4012 mbruneau@providence.on.ca

Year Program Started: 2015

Target Population: Adults with stroke who were treated at NYGH or Sunnybrook

Community Partners/Agencies: Toronto Central CCAC, Central CCAC

Impacted (Intended or actual): Those experiencing disability as a result of severe and moderate strokes

INITATIVE

One Client One Team Stroke Pathway:

We are collaborating with Sunnybrook Health Sciences Centre, North York General Hospital, Toronto Central, CCAC, and Central CCAC on a Ministry of Health and Long-Term Care (MOHLTC) integrated funding model for stroke (patient flow integration) using clinical and patient reported outcome measures to assess our success. The project aims to improve the quality of care our patients receive across three sectors and two LHINs, while also improving value-for-money for the system. The project is ensuring that people receive the care they need in the right place, at the right time, and by the right provider.

ORGANIZATION: Providence Care, Toronto

Sponsor: CHSO

Program: Rehab to the Community Transitions Program

Program Lead: Kimberly Mackenzie Manager, Relationships and Partnerships 416-285-3666, Ext. 3779
kmackenzie@providence.on.ca

Year Program Started: 2010

Target Population: Frail seniors

Community Partners/Agencies: Variety Village

Impacted (intended or actual): Seniors post rehab programs to continue to maintain or build upon gains made in rehab- from patient to person

INITATIVE

Rehab to the Community Transitions Program:

This is an integration project with Variety Village, a community-based fitness, sports and life skills facility, to support rehab patients in making a successful transition home. We are tracking the number of patients attending, data and metrics to assess outcomes and participants' satisfaction.

ORGANIZATION: Providence Care, Toronto

Sponsor: CHSO

Program: Community Referral Pathway for Frail Seniors

Program Lead: Kelly Tough, Manager, Patient Flow 416-285-3666 Ext. 4382 ktough@providence.on.ca

Year Program Started: 2014

Target Population: Frail seniors

Community Partners/Agencies: Michael Garron Hospital (formerly Toronto East General Hospital), the Scarborough Academic Family Health Team, the Toronto Central CCAC, and the Central East CCAC

Impacted (intended or actual): Frail seniors in the community who would benefit from our programs. Primary care providers in the community who are dealing with increasingly complex frail seniors

INITATIVE

Community Referral Pathway for Frail Seniors:

We have a formal partnership with the Michael Garron Hospital (formerly Toronto East General Hospital),the Scarborough Academic Family Health Team, the Toronto Central CCAC, and the Central East CCAC to help vulnerable frail seniors to continue to live at home. We plan appropriate interventions that prevent trips to emergency rooms and/or a further decline in health status by offering rapid access to our inpatient rehabilitation programs. The program includes support with making a safe reintegration back to the community after rehabilitation. The assessment may be done by Geriatric Emergency Nurses, Nurse Practitioners and CCAC coordinators, or virtually in patients' homes or other care settings using Ontario Telemedicine Network. Referrals go to our Frailty Intervention Team (FIT).

ORGANIZATION: Providence Care, Toronto

Sponsor: CHSO

Program: Community Engagement Plan

Program Lead: Patti Enright Corporate Communications Manager 416-285-3666. Ext.4278 penright@providence.on.ca

Year Program Started: 2015

Target Population: Any Providence stakeholder – patient, family member, resident, client, partner

Community Partners/Agencies: Open to any

Impacted (intended or actual): Impact is to engage and include stakeholders in projects and decisions at Providence to improve the services we provide

INITATIVE

We developed a Community Engagement Plan to guide our conversations with stakeholders and partners, bringing value to individuals and the health care system. This Plan will serve as a guide to involving the people we care for in conversations about their *care,* the services we provide, and other issues that impact them. Our community needs to understand us, and we need to understand them - this Guide is the first step towards achieving a greater common understanding.

ORGANIZATION: St. Joseph's at Fleming and Marycrest at Inglewood

Sponsor: CHSO

Program: St. Joseph's at Fleming Community Spelling Bee

Program Lead: Vicki Bell 705-743-4744, Ext. 3014 Vicki.bell@sjfltc.com

Year Program Started: 2015

Target Population: Higher functioning residents

Community Partners/Agencies: Rotary of Peterborough

Impacted (intended or actual): Local competition, then City competition starts with 25 people and then 3

INITATIVE

Community Spelling Bee - in conjunction with local Rotary Club:

"Participated in a community Spelling Bee, put on by the local Rotary Club. This event has grown in size and importance, especially in its ability to reach out to those who may have been "forgotten" in the community."

ORGANIZATION: St. Joseph's at Fleming and Marycrest at Inglewood

Sponsor: CHSO

Program: Marycrest at Inglewood Supporting Vulnerable Residents in the Community

Program Lead: MaryAnne Linton 705-876-6111 inglewood@nexicom.net

Year Program Started: Ongoing

Target Population: Seniors 68 – 100 years of age

Community Partners / Agencies: VON, CCAC, Hospice, Community Care, GAIN's Geriatric Clinic

Impacted (intended or actual):

INITATIVE

Marycrest at Inglewood Supporting Vulnerable Residents in the Community:

"The number of vulnerable residents in our community has risen. Without the proper support, some residents are struggling to maintain their health and independence. It is of utmost importance that we continue to build bonding relationships with community partners to enhance the quality of living for our residents and to maintain a safe environment for our community. Victorian Order of Nurses (VON); Central East Community Care Access Centre (CCEC); Hospice; Community Care; and Geriatric Assessment & Intervention Network (GAIN) Clinic are a few of the community-based agencies we continue to work with."

ORGANIZATION: St. Joseph's Care Group, Thunder Bay

Sponsor: CHSO

Program: Relationship with Shelter House, Thunder Bay – addressing the root causes of homelessness

Program Lead: Tracy Buckler 807-343-2450 buckler@tbh.net

Year Program Started: 2015

Target Population: Homeless

Community Partners / Agencies: Shelter House

Impacted (intended or actual): Shelter House provides a vital service to the homeless population in Thunder Bay. The partnership between Shelter House and SJCG has elicited a number of positive initiatives to help to support this population.

INITATIVE

Relationship with Shelter House, Thunder Bay - addressing the root causes of homelessness:

"In May of 2015,Tracy Buckler was appointed as a member of the Shelter House of Thunder Bay's Board of Directors. Shelter House Thunder Bay's mission is to provide basic needs, dignity and comfort to people living in poverty and stimulates action to address the root causes of homelessness. We have many shared clients between the two organizations."

ORGANIZATION: St. Joseph's Care Group, Thunder Bay

Sponsor: CHSO

Program: Responding to Unmet Needs: Addiction, mental health, homelessness

Program Lead: Janet Sillman 807-343-4303 sillman@tbh.net

Year Program Started: 2016

Target Population: Homeless, addictions & mental health

Community Partners/Agencies: NorWest CHCs, Thunder Bay District, Social Services, Administration Board, EMS, Thunder Bay Regional, Health Sciences Centre, Community Care Access Centre, Canadian Mental Health Association, Alpha Court, Other housing providers, Primary care physicians, Ministry of Housing/North West LHIN - potential funders

Impacted (intended or actual): The ultimate goal is to establish supportive housing for people who are chronically homeless and who live with complex health, mental health and/or substance use issues. We have initiated first steps by gathering information, 40 spaces for youth and adults who are chronically homeless and establishing a co- leadership role with the NorWest Community Health Centres. We are also working with the TBDSSAB to submit an Expression of Interest to the Ministry of Housing for funding for both the capital and operating sides of the initiative. If funding becomes available, additional partnerships will be established and further planning to achieve the previously stated goal will proceed.

INITATIVE

Responding to Unmet Needs: Addiction, mental health, homelessness

"In effort to examine how to better meet the unmet needs of those in our community suffering with addiction, mental health and/or homelessness issues, Janet Sillman, VP, Addictions & Mental Health, Dr. Geoff Davis, Chief of Staff, and Dr. Jack Haggarty, Senior Medical Director, Addictions & Mental Health, visited Ottawa Intercity Health to observe and learn about the care model they have adopted."

ORGANIZATION: St. Joseph's Care Group, Thunder Bay

Sponsor: CHSO

Program: Partnership with Thunder Bay Police Service

Program Lead: Dr. Mary Ann Mountain 807-624-3434 mountain@tbh.net

Year Program Started: 2016

Target Population: Thunder Bay Police

Community Partners/Agencies: Thunder Bay Police Services

Impacted (intended or actual): The intended impact was to mitigate the effects of exposure to traumatic events and the subsequent development of PTSD. We do not have information as to whether the training achieved that goal as yet.

INITATIVE

Partnership with Thunder Bay Police Service - to recognize the signs of operational stress:

"Community Mental Health is collaborating with the Thunder Bay Police Service (TBPS) to train police officers to more easily recognize the signs of operational stress. Return to Mental Readiness (R2MR) is a training program developed by the military to increase awareness of operational stress and to make available a stepped model of accessing support. Dr. Sara Hagstrom, a psychologist with Community Mental Health, accompanied two officers from TBPS to the police college in Aylmer for a week of training. She will continue to work with the training team during the next 6-9 months to provide training to all staff of TBPS."

ORGANIZATION: St. Joseph's General Hospital, Elliot Lake

Sponsor: CHSO

Program: Partnership with the Elliot Lake Organization for Refugee Action (ELORA)

Program Lead: Thomas Bluger, former Pastoral Care worker for SJGHEL. We no longer have involvement since his retirement

Year Program Started: 2016

Target Population: Refugees

Community Partners/Agencies: Organizational ELORA was formed

Impacted (intended or actual): 2 refugee families brought to community. Cook books sold in Hospital cafeteria to help raise funds.

INITATIVE

Partnership with the Elliot Lake Organization for Refugee Action (ELORA)

Partnered with the organization to welcome 2 refugee families to Elliot Lake in 2016

Director for Pastoral Care and Volunteer services spearheaded an alliance with some of the regional clergy and their parishes to host the families

ORGANIZATION: St. Joseph's General Hospital, Elliot Lake

Sponsor: CHSO

Program: Workshops to develop cultural competency in the services provided with emphasis on First Nations

Program Lead: Tammi Beeson SJGHEL,705-848-7182 Ext. 2430 tbeeson@sjgh.ca; Cathie J Syrette, Executive Director, Indian Friendship Centre, 122 East Street, Sault Ste. Marie, ON P6A 3C6 Telephone: 705-256-5634 Ext. 2125
Fax: 705-256-8217 director@ssmifc.ca Website: http://www.ssmifc.com/

Year Program Started: 2015 and 2016. Continues in 2017 as twice yearly offering

Target Population: SJGHEL staff

Community Partners/Agencies: Offered to local family health team

Impacted (intended or actual): We have provided mandatory training for over 300 staff. This training was a 1 day course, in which each staff member was paid for their attendance. Now that the bulk of staff have been trained, we run the program twice yearly in 2017 to get all new recruits and the few stragglers that didn't make the other sessions.

INITATIVE

Workshops to develop cultural competency in the services provided with emphasis on First Nations:

•Working with the Sault Ste. Marie Indian Friendship Centre, hosted workshops for all staff to provide an understanding of the impacts of the residential school system as it relates to First Nations.

•"St. Joseph's took this proactive stance in order to help promote the health and well-being of the people we serve, to continue to foster mutual respect with the First Nations, and embrace our Mission Values of dignity, collaboration and social responsibility."

ORGANIZATION: St. Joseph's Health Centre, Toronto

Sponsor: CHSO

Program: “Brining Care to the Community” – A Key Focus

Program Lead: Dr. Heather Yang, Physician Lead 416-530-6611 hyang@stjoestoronto.ca; Allison Drabble, Patient Care Manager,1L-NICU Administrative lead 416-530-6486 Ext 3883 adrabble@stjoestoronto.ca

Year Program Started: 2016

Target Population: School-aged children, often newcomers and their families who have difficulty accessing paediatric care

Community Partners/Agencies: Toronto District School Board

Impacted (intended or actual): Improved access to primary and specialized paediatric care for children who are experiencing health challenges that may impact their academic achievement. Enhanced access to community services

INITATIVE

"Bringing Care to the Community"- A Key Focus:

In-school paediatric clinic brings care to students”….St. Joe's Toronto introduced an exciting new partnership with the Toronto District School Board (TDSB) to provide paediatric care within a school setting, improving access to important health services in the community. A new paediatric clinic, supported by a team of dedicated physicians and other specialists, is now open three days a week in Parkdale Junior Public School and is part of the TDSB's Model Schools for Inner Cities Program aimed at nurturing students' academic success through improved access to community and social supports and health services.

This is a particularly important resource in a neighbourhood like Parkdale which is home to a diverse population including many families who are newcomers to Canada."

ORGANIZATION: St. Joseph's Health Centre, Toronto

Sponsor: CHSO

Program: Award-winning paediatric clinic brings care to students

Program Lead: Dr. Daphne Williams, Physician Lead, Family Health Team dwilliams@stjoestoronto.com 416-530-6860; Alejandra Prego, Patient Care Manager/Administration Lead aprego@stjoestoronto.ca 416-530-6860

Year Program Started: The Family Medicine practice opened its doors in 1989 and expanded to become a comprehensive Family Health team (FHT) in 2007.
Over the years, the FHT has expanded their program offerings to enhance support available for specific marginalized populations.

Target Population: Pregnant women who face addictions, adults who face addictions and substance abuse issues; People facing mental health issues, frail elderly people who have mobility issues

Community Partners/Agencies: Four Villages Community Health Centre, Parkdale Community Health Centre, liberty Family Health Team, Toronto Public Health Regeneration House

Impacted (intended or actual): Outreach to people who are marginalized and experience barriers to accessing healthcare. We provide primary health care to improve their health across the life span

INITATIVE

Award-winning Family Health Team serves the community, in the community:

"Our role as a community health centre means that we must continue to explore ways we can advance the health of our community, by being in the community. Along with the opening of our new school paediatric clinic, last year we celebrated the success of our Urban Family Health Team as the 2015 recipient of the Ontario College of Family Physicians Family Practice of the Year Award.

For over 26 years, our Family Medicine Team has served people living in Toronto's west-end neighbourhoods. The Urban Family Health Team, which has offices in the community and onsite at the hospital, serves a diverse population whose experience with the healthcare system varies widely. The team has made care more accessible by offering flexible and evening appointments and visits to elderly clients who can't leave their homes. It also offers a number of programs for pregnant women, people with chronic diseases and people with mental health challenges.

ORGANIZATION: St. Joseph's Sudbury

Sponsor: CHSO

Program:

Program Lead:

Year Program Started:

Target Population:

Community Partners/Agencies:

Impacted (intended or actual):

INITATIVE

St. Joseph's Health Centre has worked to develop partnerships that focus on care for the vulnerable within our community. Such partnerships include:

1. North East Specialized Geriatric Centre (NESGC) We have partnered with NESGC, which is a multidisciplinary team of health care providers who deliver specialized care for older adults with complex health needs, as well as expert resources for health care professionals and caregivers throughout Northeastern Ontario. Through this partnership, we have increased our opportunity toward the development of a Geriatric Day Program.

2. Rehabilitative Care Alliance re: bedded levels of care Worked with NESGC and system partners to develop a proposal that was submitted on December 31, 2014, to the MOH&LTC for a pilot project to more effectively identify patients in need of Assess and Restore (A&R) programming.

Working with the A&R subcommittee of the \IE LH1N CCC/Rehab Steering Committee to implement the Assess Restore guidelines rom the MOH&LTC across our region.

Ensured that internal practices were in alignment with the best practices set out in the guideline.

Obtained NTCHE designation and provide education to all nursing staff at SJCCC on geriatric giants to better meet the needs of A&R patients.

3. University of Dalhousie re: Palliative and Therapeutic Harmonization (PATH) Program St. Joseph's Continuing Care Centre is the first continuing care centre to embark upon implementing the PATH program. PATH is a process that helps older people and their families understand their health status and guide them through the process of making health care decisions that protect their best interests and quality of life. The goal of PATH is to help patients and families choose a blend of therapeutic and palliative measures that will best preserve an individual's quality of life in their remaining time.

SJCCC has partnered with the University of Dalhousie. The SJCCC inter-professional team are working with two key experts (Dr. Paige Moorhouse and Dr. Laurie Mallery) at the PATH clinic in Halifax to finalize an implementation plan. Once the plan is finalized the PATH tools and process will be trialed at SJCCC and then rolled out to our two long-term care facilities.

4. President & CEO has been actively meeting all year with various stakeholders on topics of assisted living opportunities, seniors' concerns/projects, health service delivery within the community.

ORGANIZATION: St. Michael's Hospital, Toronto

Sponsor: CHSO

Program: 2015-2018 Strategic Plan

Program Lead: Dr. Robert Howard, CEO (416) 864-5600 HOWARDR@smh.ca

Year Program Started: This has been a key focus of St. Michael's Hospital since its inception. The current Strategic Plan was launched in 2015.

Target Population: The strategic focus encompasses a number of vulnerable or marginalized patient populations (further described in the programs below)

Community Partners/Agencies: Various community agencies and hospital partners within the Toronto Central Local Health Integration Network (TC LHIN)

Impacted (intended or actual): St. Michael's, Toronto's "Urban Angel", is recognized by the health system and the public as the leading acute care teaching hospital in the Greater Toronto Area in caring for disadvantaged populations.

INITATIVE

2015-2018 Strategic Plan:

Within its current strategic plan, St. Michael's has prioritized advance systems of care for patients who experience disadvantage.

Balancing the continued commitment to the care of the poor and those most in need with the provision of highly specialized services to a broader community.

ORGANIZATION: St. Michael's Hospital, Toronto

Sponsor: CHSO

Program: Patients who experience Disadvantage Strategic Priority Steering Committee

Program Lead: Dr. Douglas Sinclair, EVP/CMO and Executive Sponsor of this steering committee 416-864-5484 SinclairD@smh.ca

Year Program Started: Established as part of the implementation of the current strategic plan in 2015

Target Population: Focus on people in the lowest income quintile experiencing disadvantage related to factors of social exclusion which present added challenges to receiving appropriate care and support; these factors include mental health and addiction; vulnerable housing or homelessness; aboriginal, immigrant or refugee status; sexual orientation; and gender identity.

Community Partners/Agencies: This steering group provides stewardship and guidance across all hospital programs at a corporate level. Different initiatives may have different community partners, but would include community agencies, health service providers, and social service agencies within the local catchment of St. Michael's Hospital and within the TC LHIN

Impacted (intended or actual): Through the Inner City Health Program, the hospital has served countless patients who experience disadvantage (see below). This past year this steering committee supported the development of an addictions strategy that will be further explored with care providers and community partners in the coming year.

Through the Centre for Urban Health Solutions, it has provided research expertise in the design, evaluation, implementation and dissemination of innovative models of care for disadvantaged populations.

Developed collaborative learning programs for staff and physicians in the care of disadvantaged

Partnered with the TC LHIN in testing new ways of engaging local residents from a variety of circumstances including those who experience disadvantage

INITATIVE

Patients who experience Disadvantage Strategic Priority Steering Committee:

This past year the committee focused on three main initiatives including: Developing an addictions strategy for the hospital

Developing education knowledge exchange programs for health care providers regarding key aspects of appropriately and respectfully providing care for those who experience disadvantage

Launching the newly refocused Centre for Urban Health Solutions and its initial signature research programs

ORGANIZATION: St. Michael's Hospital, Toronto

Sponsor: CHSO

Program: Inner City Health Program

Program Lead: Dr. Douglas Sinclair, EVP/CMO and Executive Sponsor of this steering committee 416-864-5484 SinclairD@smh.ca

Year Program Started: Long standing program of the hospital, established in the mid-1990's

Target Population: We care for people with severe and persistent mental illnesses and substance abuse issues, refugees, immigrants, vulnerable seniors, people with disabilities, people who are homeless or underhoused, and those challenged by other social determinants of health.

Community Partners/Agencies: Inner City Health Associates, local community agencies such as Regent Park Community Health Centre, Woodgreen Community Services, etc.

Also work with cross sector partners including various social service agencies, local school boards, law enforcement, and others.

Impacted (intended or actual): Our Inner City Health Program has provided quality care to countless patients over the years, and works with community partners to establish innovative programs and supports within the community for those who are most vulnerable.

Over 73,000 emergency visits annually
Over 40,000 rostered patients in our Family Health team
Over 2700 babies born annually

Example: Rotary Transition Centre within the Hospital Emergency Department provides safe space to recover after treatment in the emergency department.

INITATIVE

Inner City Health Program:

Our Inner City Health Program is the only program of its kind in Canada, with a clear definition, a research component and a structure for community input through our community advisory panels. Through our integrated approach to community health, we combine medical, psychological and other types of care, and co-ordinate with local partners.

This program encompasses a number of services within the hospital including Mental health, Emergency Department, General Internal Medicine, Geriatric and Stroke Programs, Women's Health and Pediatrics, and our Family Health Team which provides primary care.

We serve a population as diverse as the multicultural communities who live and work every day in the heart of our ever evolving city.

ORGANIZATION: St. Michael's Hospital, Toronto

Sponsor: CHSO

Program: Centre for Urban Solutions

Program Lead: Dr. Arthur Slutsky, VP Research (416) 864-5637 SLUTSKYA@smh.ca; Dr. Stephen Hwang, Director Centre for Urban Health Solutions (416) 864-6060 Ext. 77311 HWANGS@smh.ca

Year Program Started: Founded in 1998 and rebranded / refocused in 2016 to become the Centre for Urban Health Solutions

Target Population: The Centre focuses on solutions based research that seeks to improve overall health in cities, especially for those populations that may be marginalized or must vulnerable due to a variety of factors

Community Partners/Agencies: The Centre partners with the hospital and its programs as well as key partners including: Well Living House (an action research centre for Indigenous infant, child and family health and wellbeing) and the Survey Research Unit also based at St. Michael's which provides capacity to undertake large scale qualitative and quantitative research.

Impacted (intended or actual): The Centre's current project focus on:

1) Building healthy policy and practices
2) Addressing barriers and identifying gaps in health-related services
3) Reducing transmission of sexually transmitted infections
4) Improving services for people dealing with homelessness and housing instability

Example: The CLEANmeds study led by Dr. Nav Persaud has demonstrated the benefit of providing free access to a list of carefully chosen essential medications. This research study has already informed public policy - The government of Ontario in its recent budget announced a pharmacare program for youth.

INITATIVE

Centre for Urban Health Solutions:

The Centre for Urban Health Solutions (founded in 1998 as the Centre for Research on Inner City Health), is an inter-disciplinary research centre within St. Michael's Hospital in Toronto. The Centre seeks to improve health in cities, especially for those experiencing marginalization, and to reduce barriers to accessing factors essential to health, such as appropriate health care and quality housing. We are committed to developing and implementing concrete responses within health care and social service systems and at the level of public policy.

ORGANIZATION: Waypoint Mental Health, Penatanguishene

Sponsor: CHSO

Program: Waypoint has a history of over 110 years servicing those most in need

Program Lead:

Year Program Started:

Target Population:

Community Partners/Agencies:

Impacted (intended or actual):

INITATIVE

Waypoint has a history of over 110 years serving those most in need.

Our strategic plan includes both an objective to increase advocacy and community understanding of mental health, and a strategic direction of partnerships in order to improve care and services, build knowledge and enhance system capacity and sustainability.

Mental Health and Addiction Services

... improving access to high quality mental health and addiction services as a priority. Waypoint continues its leadership of the regional team leading this work and is also active on all sub groups.

Examples:

Mental Health First Aid

The 12-hour course, geared toward non-clinical staff and the community at large, provides general information about what is meant by mental health problems and illnesses, how to identify signs of mental health problems in yourself and others, effective interventions and treatments, and how to support an individual and help them find out about and access the professional help they may need. It also dispels common myths surrounding mental health problems and reduces the stigma around mental illness.

Local, Provincial and Regional collaboration and partnerships - a priority

Working together to improve the system is an objective across the health care sector, and Waypoint continues to maintain a high level of involvement both provincially and regionally.

- Specialized geriatrics services: diagnose, treat and rehabilitate frail seniors
- Road to Recovery Housing Project
- Fist Nations, Metis and Inuit research

ORGANIZATION: St. Joseph's Villa Dundas

Sponsor: St. Joseph's Health System

Program:

Program Lead: Tamara Johnson (905)627-3541 Ext. 2291 tjohnson@sjv.on.ca

Year Program Started: 1972

Target Population: Frail older adults, adults with physical disabilities, dementias and other cognitive impairments, and their caregivers

Community Partners/Agencies: We very much appreciate the support of the HNHB CCAC, local community agencies, and local philanthropists.

Impacted (intended or actual): To provide low cost day care alternatives to older adults and their caregivers, so that clients stay active and engaged while caregivers have respite, can work, and can manage while waiting for an long term care placement.

INITATIVE

Our Adult Day Program embraces the heritage and ministry of the Sisters of St. Joseph's, and recognizes the value of every individual as we support their independence through innovative practices. Our programs help provide low cost caregiver relief, options while waiting for long term care, and a safe place for loved ones while a caregiver is at work? There are four programs offered Monday-Friday including fitness programs in our adaptive gym, recreational programs that include crafts, baking, and working in our "Enchanted Garden," and programs to keep the memory and imagination sharp. Each program is Jed by a Recreationist and supported by a Program Assistant (Certified Health Care Worker), and Occupational/Physical Therapy Assistant. Individual assessments and geared-to-abilities programming assist the adult participant to achieve and maintain their maximum level of functioning, prevent premature institutionalization, and provide respite and support to caregivers. We have a unique specialized program, conducted in a secure home-like environment, available for clients with significant cognitive impairment due to Alzheimer disease or dementia. Programs include: daily exercises, enchanted garden, adult gym, clinics (ent, skin, dental, wound),games and trivia, social programming, entertainment, pottery, snoezelen, montessori activities, zumba, guest speakers, themed events, bowling alley and crafts.

ORGANIZATION: St. Joseph's Health System

Sponsor: St. Joseph's Health System

Program:

Program Lead: Gary Payne 905-522-1155 Ext.33264 gpayne@stjosham.on.ca

Year Program Started: Some parts of the project started more than 20 years ago

Target Population: Support for people who are financially disadvantaged when:* a loved one has died including a pregnancy loss * a baby has been born

Community Partners/Agencies: We are supported by the Sister's of St. Joseph and work with many community spiritual and religious practitioners

Impacted (intended or actual): Ensure that patients who are financially disadvantaged have newborn baby supplies including refugees, single parents and those on social assistance Ensuring that families of patients who have died, who are financially disadvantaged can have a funeral for their loved one

INITATIVE

For many years the Sisters of St. Joseph of Hamilton have, through the Spiritual Care Department, provided newborn supplies for families, couples and single parents who are refugees, new arrivals, or are on social assistance. When needed we also provide funerals and committal services for: * clients who are buried at the public expense * couples and single moms who have experienced pregnancy losses (stillbirth and miscarriage) and need municipal assistance for the burial It is very important to us that every life, and life lost, is valued and recognized as a life of equal worth

ORGANIZATION: St. Joseph's Home Care

Sponsor: St. Joseph's Health System

Program:

Program Lead: Lori Lawson 905-522-6887 Ext. 2238 llawson@stjhc.ca

Year Program Started: More than 20 years for some programs

Target Population: Financially disadvantaged home care clients at risk of health crises, unstable home environments and social isolation.

Community Partners/Agencies: We have many community partners - see program descriptions.

Impacted (intended or actual): The goal of these programs is to work with partners to create a wide range of services that support financial disadvantaged people to keep them healthy, stable and socially connected. Our staff are very sensitive to the importance of ensuring that the dignity of those served is protected. These programs also reduce the costs in hospitals and long term care

INITATIVE

Community Wellness Program To fulfill the mission of the Sisters, we have allocated a percentage of our net assets per annum for vulnerable seniors in the community who need assistance with cleaning, falls prevention equipment and foot care. Community Connector Role (Social Isolation for Seniors Project) St. Joseph's Home Care as part of the Hamilton Seniors Isolation Reduction Impact Plan has received three year funding for the role of a Care Connector. The goal of the Care Connector is improving and coordinating supports to seniors being discharged from the hospital that will enable them to transition back to the community by anchoring them into community services or other supports that engage the seniors and reduce isolation. Financial assistance is provided for transportation and cleaning. Transitional Bed Program at First Place This is a 32 bed program located at First Place Assistive Living unit for clients who are transitioning from the hospital and community to another supported living environment such as long-term care or retirement home. Target length of stay is 60 days. This program is a partnership between St. Joseph's Home Care, St. Joseph's Healthcare Hamilton, Hamilton Health Sciences and the Hamilton Niagara Haldimand Brant Local Health

Integration Network. We offer a lower per diem rate for clients who have limited finances. Gwen Lee Supportive Housing This program is located in an apartment building managed by City Housing Hamilton. The on-site Support Services Manager oversees and co-coordinates the services for Gwen Lee clients.

Support services are provided by Personal Support Workers who are on site 24 hours a day. Each apartment has an emergency response system installed for 24 hours assistance. There is no charge for personal support services. Out of the Cold Foot Care St. Joseph's Home Care, as part of the Out of the Cold initiative, provides free foot care services for individuals, who are homeless or at risk of being homeless. Services are provided at the James Street Baptist Church during the winter months. United Way Cleaning St. Joseph's Home Care receives funding from the United Way to provide cleaning services for approximately 40 seniors, who have limited income so that they can live safely and independently at home. Santa's Helper Program For the past 20 years, the Santa Senior Project, a registered charity through the Hamilton Academy of Hamilton provides Christmas gifts to approximately 60 of our clients, who have limited finances and social supports. Neighbourhood Model for Seniors at Risk St. Joseph's Home Care operates 'Coffee Hour' for 30-40 tenants of 226 Rebecca Street apartment (City Housing Hamilton) twice a week. The purpose of this program is to provide refreshments, socialization and topics of interests for seniors at no cost to them.

ORGANIZATION: St. Joseph's Healthcare Hamilton

Sponsor: St. Joseph's Health System

Program:

Program Lead: Claire Kislinski & Fiona Wilson 905-522-1155 Ext. 32297 905-522-1155 Ext. 36446 ckislins@stjosham.on.ca fwilson@stjosham.on.ca

Year Program Started: 2017

Target Population: People in Hamilton downtown neighbourhoods who are not accessing mental health and addiction services.

Community Partners/Agencies: The is a joint project with Mission Services in Hamilton http://mission-services.com/ Mental Health Safe Space was created from a joint research initiative called the EXTRA project, led by St. Joseph's Healthcare Hamilton and Mission Services Hamilton. Mental Health Safe Space is a pilot project that is currently funded by a seed grant from the Ontario Trillium Foundation to continue until December 2017. Currently 10 businesses and organizations have volunteered to be Safe Spaces: River Trading Co. Mission Services of Hamilton, Community Services Vagabond Saints De Mazenod Door Ministry at St. Patrick's Church Helping Hands Street Mission Fan-Tastic Scholars East Inc. Barton Street branch of the Hamilton Public Library 541Eatery & Exchange Barton Village Business Improvement Area office The Second Bowl

Impacted (intended or actual): To take mental health care, and access to services, out into the community by working with the community and local businesses. This helps: * create local points of access in your neighbourhood that are highly visible in local businesses and organizations * provides a place to go in a crisis where a caring neighbour will connect you to services * signals that your community cares about you if you are ill * builds understanding and engages the community to breakdown stigma * brings the hospital out into the community

INITATIVE

St. Joe's partners with Mission Services to create innovative project where

Neighbours create a safe space for those suffering mental illness. https://www.stjoes.ca/our-stories/news/'"1798- Bringing-mental-health-support-to-where-people-live The focus of the project was to work collaboratively with an inner city neighborhood to identify and implement improvement initiatives that decrease barriers to care at St. Joseph's Mental Health and Addiction Program outpatient services. There are currently 10 local businesses and organizations that have volunteered to be Safe Space designated. These businesses will be recognizable by the prominent placement of a Mental Health Safe Space logo in a street-facing window and each designated Safe Space has trained Community Champions who work in these organizations. The Community Champions will provide support and reduce stigma by recognizing someone in distress. Currently 34 community champions have been trained. The Champions have access to the resources and information to refer someone to a Safe Space Community Connector who can provide extra support, resources and help to access services. Research will continue on the project to evaluate its success.

ORGANIZATION: St. Joseph's Healthcare Hamilton

Sponsor: St. Joseph's Health System

Program:

Program Lead: Peter Bieling (Clinical Director) & Lisa Jeffs (Project Manager) (905)522-1155 ext. 35015, (905)522-1155 ext. 36238 pbieling@stjosham.on.ca, ljeffs@stjosham.on.ca

Year Program Started: March 2015

Target Population: Young people who are: 1. experiencing emerging mental health and addiction concerns. 2. transitioning from child mental health services to adult mental health and addiction services. 3. local college and University students who are facing significant barriers to accessing care for their mental health and addictions concerns

Community Partners/Agencies: We have many community partners and appreciated the support of the HNHB LHIN. We are closely partnered by, and share space with, Alternatives for Youth. An organization that provides services for customized services for youth (aged 12 to 22) dealing with drug and alcohol addictions. http://ay.on.ca/

Impacted (intended or actual): In Ontario there are well known cases of young people who fall through the cracks between the youth and adult mental health systems. There is also insufficient access to mental health and addictions services for youth, which creates significant stress and challenges for youth and parents. After a presentation to our Board and Senior Leadership Team, by a parent whose daughter committed suicide and whose story identified the gaps in the health system, we set out on a five year process to create a highly accessible youth wellness centre in the downtown core of Hamilton. Using population health data we set out to make a significant impact on service gaps and accessibility issues. We were very aware that the target population could be difficult to reach. From very early in the project we engaged with young people to shape the programming and 'feel' of the services and environment. The centre continues to grow and recently celebrated an expansion.

INITATIVE

St. Joseph's Healthcare Hamilton's Youth Wellness Centre is a unique service that provides expert mental health care by appointment including counselling, support and navigation services for young people aged 17 to 25. This service is covered by OHIP and confidential. http://www.stjoes.ca/hospital-services/mental-health-addiction-services/mental-health-services/youth-wellness centre Unlike other specialized services, our centre accepts self-and family/friend referrals in order to decrease barriers and make our services more accessible. Medical professionals and service providers can also refer their clients. We offer Early Intervention, Transition Support, and a Mobile Team. The Youth Wellness Centre is a safe, accessible environment for young people age 17 to 25 to receive expert care for mental health and addiction issues. The Youth Wellness Centre is located in downtown Hamilton. We offer confidential clinical care for young people who are: 1. experiencing emerging mental health and addiction concerns. This stream is called Early Intervention. 2. looking for support transitioning from child and adolescent mental health services to adult mental health and addiction services. These services are delivered by St. Joseph's Healthcare Hamilton's adult Mental Health and Addictions Program and our community partners. This stream is called Transition Support. 3. students of Mohawk College, McMaster University, or Redeemer University College, and/or who are facing significant barriers to accessing care for their mental health and addictions concerns. This support is provided by our Mobile Team.

ORGANIZATION: Hotel Dieu Grace Healthcare Windsor, Ontario

Sponsor: Catholic Health International

Program:

Program Lead: Sonja Grbevski, Vice President, Brain & Behaviour Health (519)257-5111Ext. 73544 sonja.grbevski@hdgh.org

Year Program Started: December 2016

Target Population: Individual's with Mental Health and Addictions related issues

Community Partners/Agencies: Windsor-Essex Canadian Mental Health Association Windsor Police Services OPP- Essex Detachment Downtown Mission Windsor Regional Hospital City of Windsor and the Windsor Essex County Housing Corporation Hotel-Dieu Grace Healthcare Withdrawal Management. The Salvation Army Street Health Mental Health Connections Victorian Order of Nurses Homeless Coalition

Impacted (intended or actual): Housing, primary medical care, financial support, psychiatric consultation, symptom management and coordinating services are primary functions, as well as community outreach. The medical and psychosocial needs identified on admission and throughout their stay will be addressed through individualized care/support planning involving the client, informal supports and the primary care staff. Individualized service/care plans will be developed in collaboration with clients and community service providers to ensure wrap-around services are accessed in the community. Assessment of functional skills by the program Occupational Therapist (OT) will allow for education and support to develop the skills necessary for maintaining stable housing and managing finances. Will support harm reduction, identifying and managing individual safety issues/concerns and partaking in the development and improvement of functional skills not limited to: - Understanding Concurrent Disorders and Mental Illness- Harm Reduction Strategies - Relapse Prevention- Cognitive Restructuring - Emotional regulation- Non-medication management of symptoms of mental illness and addictions - Recovery

INITATIVE

The Transitional Stability Centre (TSC) will provide day services and support to individuals 18 to 65 years of age who are experiencing an acute mental health and/or substance use episode, but do not require hospitalization or hospital treatment. The program is designed to improve client outcomes, reduce system wide costs and enhance community wide capacity across all sectors. These voluntary services will benefit individuals who are often treated by the Emergency Department, ambulance and police services. This marginalized population is primarily difficult to engage but do not present a danger to self or others. They are often homeless or at risk of homelessness, or in sub-standard living conditions. These clients are likely already receiving services from various agencies, but present to the ED when situational crises arise. The Transitional Stability Center Goals:1) To improve symptoms of mental illness and addictions. 2) To procure appropriate medical and psychiatric services. 3) To ensure the provision of individualized outreach services upon discharge. 4) To secure stable housing upon discharge. 5) To secure adequate oversight of personal finances. 6) To divert from the Emergency Department and jail, wherever possible

ORGANIZATION: St. Joseph's Continuing Care Centre

Sponsor: Catholic Health International

Program:

Program Lead: Wendy Macinnis (Clinical) & Leesa McNally (Therapy) (613)933-6040 Ext. 21169, (613) 933-6040 Ext. 21177
wmacinnis@sjccc.ca, lmacnally@sjccc.ca

Year Program Started: Although our facility has always offered activation and restoration services our facility has a new found commitment since the Fall of 2016 to transition to community seniors who require strengthening and reconditioning and/or rehab recovery after surgery.

Target Population: Seniors who require strengthening and reconditioning and/or rehab recovery after surgery.

Community Partners/Agencies: We work closely with the Cornwall Community Hospital and our Champlain LHIN (CCAC) in order to transition our patient seamlessly from hospital to community.

We also work closely with various community partners such as retirement homes, the Red Cross all in an effort to identify alternatives when a discharge to home is no longer an option.

Impacted (intended or actual): The impact is that in less than 12 months we have increased the capacity of this service by managing our admissions and discharges and by respecting that all patients meet the criteria for the program. Specifically our patients must commit to the therapy program and meet an average length of stay of 90 days.

In the fall of 2016 we had 18 slow stream rehabilitation beds with an average length of stay of over 350 days. Our discharges would account for approximately 4-5 per month.

Today, we have 30 beds available for slow stream rehabilitation and our stats demonstrate that our patients stay 33.3 days. We discharge on average 27 patients per month and our community hospital which accounts for one of the highest overcapacity organization in our LHIN considers SJCCC a true partner.

Our efforts are now being directed towards increasing our compliment of therapies and increasing the variety of therapy related activities available for our patients.

INITATIVE

The program is adaptable to a wide variety of post surgical candidates including programs for both weight- bearing and non-weight bearing status and fractures.

Post-Surgical:

Services to increase independence, regain lost skills, reduce risk of falls, and promote autonomy in the community (home, assisted living and retirement settings).

Short Term Complex Medical:

Services for patients requiring a short-term medical stay for whom a discharge to home is foreseeable within 90 days. Services may include wound management, IV therapy, pain control, or stabilization of complex medical issues.

Bariatric:

Restorative care service specifically designed for the needs of bariatric patients who have short term needs before returning to home.

ORGANIZATION: Hotel Dieu Shaver Health and Rehabilitation Centre

Sponsor: Catholic Health International

Program:

Program Lead: David Ceglie, Vice President Clinical Services (905)685-1381 Ext. 85317 david.ceglie@hoteldieushaver.org

Year Program Started: 2012

Target Population: Residents within Niagara region living with Parkinson's disease

Community Partners/Agencies: This program was established through a partnership with a local foundation referred to as the Steve Ludzik Parkinson's Foundation. This program is not funded by the Ministry of Health, so we rely 100% on the community donations to run this program. In addition to the Steve Ludzik Parkinson's Foundation, we receive donations from our community, some of these donations are very substantial, ensuring our program is sustainable for the current year and for years to come.

Impacted (intended or actual): Standard outcome measures are utilized and captured during the course of the program. Overall, our patient specific outcome measures have shown an improvement to the individual after completing this program. These outcomes are measured again six weeks post completion of the program to see if the gains are maintained.

INITATIVE

Across Canada there are limited outpatient rehabilitation programs available that are aimed at assisting those living with Parkinson's disease with improving and optimizing their quality of life. The Steve Ludzik Centre for Parkinson's rehab was developed and implemented to meet that need and fill that cap. The program is designed to: (A) provide time limited rehab treatment by an interprofessional team, (B) incorporate rehabilitation through both individual and group treatment approaches, (C) assist patients and their families in taking an active role to achieve their optimal level of function, increase daily independence and improve their overall quality of life.

ORGANIZATION: Hotel Dieu Shaver Health and Rehabilitation Centre

Sponsor: Catholic Health International

Program:

Program Lead: David Ceglie, Vice President Clinical Services (905)685-1381 Ext. 85317 david.ceglie@hoteldieushaver.org

Year Program Started: 2015

Target Population: Those living in the Niagara region who are experiencing challenges with memory loss and who are not members of a local family health team that offer this service.

Community Partners/Agencies: The program was established in partnership with local family physicians and through the support of the Alzheimer Society of the Niagara region. The program is not funded by the Ministry of Health, therefore the success of this program is very much dependent on the support of the local family physicians, the Alzheimer Society and the ability of the Hotel Dieu Shaver to continue to allocate resources to this program in the future.

Impacted (intended or actual): By receiving memory clinic intervention at the right time, patients will be able to optimize their functional independence, slow down their progression of memory loss and delay significant cognitive deficits. Such results will lead to strengthening an aging at home strategy at a local level.

INITATIVE

Hotel Dieu Shaver's Memory Clinic is an innovative interprofessional clinic that is modeled after the memory nic program established by Dr. Linda Lee, at the centre for family medicine in Kitchener, Ontario. Since Hotel Dieu Shaver implemented our 2 half day per month memory clinic program ,our referral volumes continue to aggressively increase. Our memory clinic assesses patients who have been identified as having memory impairment by their physicians, family or themselves. The patients are seen by a specially trained interprofessional healthcare team and undergo extensive assessment. All patients, whether or not they have evidence of memory loss, are educated about preventative strategies for preserving brain health. If there is objective evidence of cognitive loss, appropriate prevention and treatment strategies are implemented,which may include medication optimization, education and referral to appropriate community resources. This model allows for improved care at every stage of the Dementia Care Continuum.

ORGANIZATION: St. Joseph's Health Care Society

Sponsor: CHSO

Program:

Program Lead: Karen Perkin

Year Program Started: February to March 2016

Target Population: Syrian Refugees

Community Partners/Agencies: Thames Valley Family Health Team; the london InterCommunity Health Centre; Cross Cultural Learner Centre

Impacted (intended or actual): About 500 refugees received much needed health care and referrals to other health providers.

INITATIVE

During February and March 2016, three St. Joseph's staff members became a mini mobile medical team in response to an urgent request by the South West LHIN for help in meeting the health care needs of London's Syrian refugees. One of our Nurse practitioners, an Operating Room nursing unit secretary and an admitting clerk were deployed to support health assessments for Syrian refugees. They were part of a partnership with other community agencies addressing the health care needs of the Syrian newcomers that require immediate attention.

ORGANIZATION: St. Joseph's Health Care Society

Sponsor: CHSO

Program:

Program Lead: Dr. Michael Silverman

Year Program Started: 2015 – ongoing

Target Population: Intravenous drug users with HIV/marginalized individuals with HIV

Community Partners/Agencies: London InterCommunity Health Centre

Impacted (intended or actual):

INITATIVE

Access to crucial HIV/AIDS treatment has dramatically improved for marginalized individuals in London's inner city through a partnership between St. Josephs' and London InterCommunity Health Centre.

With many individuals with HIV and hepatitis C experiencing difficulty accessing care or are reluctant to seek treatment at a hospital, St. Joseph's and LIHC collaborate to provide a clinic twice a month at LIHC where St. Joseph's specialist, see patients with HIV.

ORGANIZATION: St. Joseph's Health Care Society

Sponsor: CHSO

Program:

Program Lead: Nancy Townsend

Year Program Started: 2015 – ongoing

Target Population: Anyone living with HIV in London

Community Partners/Agencies: Patients, community partners – such as Regional HIV/AIDS Connection

Impacted (intended or actual):

INITATIVE

The Infectious Diseases Care Program (IDCP) implemented an important new role- peer mentor- to provide support to individuals newly diagnosed with HIV. The peer mentor provides a safe place for individuals to ask questions helps them understand HIV, and assists them in getting the care they need. The peer mentor knows what it's like to live with HIV because they live with it too.

The idea was raised at an IDCP Community Advisory Committee, a group made up of IDCP team members, patients and community partners. St. Joseph's peer mentor program is open to anyone in the London area living with or at risk of HIV infection.

ORGANIZATION: St. Joseph's Health Care Society

Sponsor: CHSO

Program:

Program Lead: Noelle Tangredi 65461 Noelle.tangredi@sjhc.london.on.ca

Year Program Started: 2015

Target Population: People with dementia, a mental illness, ADHD or who are palliative or in an emergency room

Community Partners/Agencies: Alzheimer's society and North American knitters

Impacted (intended or actual): Individuals from across Southwestern Ontario and now Nationally

INITATIVE

Three team members from Organizational Development and Learning Services began knitting hand muffs during their breaks. These hand muffs provide stimulation and reduce anxiety for people with dementia. They are knit with various textures of wool with objects like buttons, strings and beads attached to keep hands warm, and to provide visual, tactile and sensory stimulation.

They have provided hand muffs to many areas of care beyond dementia, including palliative care, mental health care and emergency rooms, as well as to autistic children and youth with anxiety or ADHD (attention deficit hyperactivity disorder).

In January 2016, the hand muff project was introduced on St. Joseph's website and by local media, resulting in a surge of interest from the public. Since then, the knitting trio has received dozens of requests from across North America for the pattern, Reader's Digest featured the story, and 23,000 people have visited the web page for instructions on how to knit the muffs.

ORGANIZATION: St. Joseph's Health Care Society

Sponsor: CHSO

Program:

Program Lead: David Ross, Laura Dockstader

Year Program Started: Annual initiative (2017 campaign was the 10th year; making over $1M raised in total)

Target Population: Our own St. Joseph's patients AND those living in our community who are in need, vulnerable, without a voice

Community Partners/Agencies: United Way of Middlesex Elgin

Impacted (intended or actual): Highest needs within clinical programs supported each year at St. Joseph's;106 community agencies via United Way

INITATIVE

Share the Spirit is St. Joseph's annual employee giving campaign where staff and physicians are encouraged to donate, and thereby support,St. Joseph's Health Care Foundation, United Way or both, helping to improve the lives of people in our community.

Monies donated to the Foundation assist in supporting the highest priority needs essential to the lives of patients and residents across St. Joseph's.

Dollars contributed to United Way Elgin Middlesex are invested in 106 programs proven to get positive results and create lasting change for countless individuals. As a joint campaign, Share the Spirit impacts the lives of those we serve inside our walls and beyond.

The Ark Aid Street Mission in London received a gourmet meal from St. Joseph's. Chefs in uniform, juicy roast beef, homemade gravy, potatoes, and mixed green salad and freshly baked banana bread were served up by members of St. Joseph's Food and Nutrition Services staff, who prepared and cooked. A team of 6 members included a member who paid for the food out of her own pocket, including ingredients for the main meal, including 50 pounds of beef and 40 pounds of potatoes. The team spent five hours preparing the meal in the Ark Aid kitchen before the doors.

The endeavor was so rewarding and inspiring that the chefs decided to collectively sponsor a meal, as did two additional St. Joseph's team members; which means three additional future meals at the Ark Aid for those most in need.

ORGANIZATION: St. Joseph's Health Care Society

Sponsor: CHSO

Program:

Program Lead: Jacobi Elliott, Jacobi.elliott@sjhc.london.on.ca

Year Program Started: 2017

Target Population: Year 1 – Specialized Geriatric Services and Spinal Cord Rehabilitation

Community Partners/Agencies: Change Foundation

Impacted (intended or actual): Since the Improving CARE Together project launched in April 2017, more than 140 staff, 7 physicians and 75 family caregivers have shared their feedback on caregiver experiences at St. Joseph's. The majority of these participants were from Specialized Geriatric Services and Spinal Cord Injury Program at Parkwood Institute, the first areas of focus for the project.

INITATIVE

In St. Joseph's 2015-2018 strategic plan, the organizations set a goal to, "Ensure patients and families are full partners in their care, and in the design, measurement and improvement of care." St. Joseph's partnered with the Change Foundation on a project called Improving CARE Together.

The goal is to improve family caregiver experience and engagement across St. Joseph's and addressing Changing CARE's four key needs identified by caregivers and health care providers: communication, assessment, recognition and education. This is a 3 year project following a co-design approach. Each section of the project will focus on different care areas across St. Joseph's. When focusing on a care area, the project team goes through six phases of co-design:

Phase 1 - Project start up, identifying the project team

Phase 2 and 3: collecting feedback from family caregivers and health care providers

Phase 4 - coming together to listen, talk and decide what themes of caregiver experiences we are going to focus on. Family caregivers and health care providers will partner together to co-design ways to improve care experiences

Phase 5 - implementing the changes

Phase 6 - evaluate, measure and spread across St. Joseph's

ORGANIZATION: St. Joseph's Health Care Society

Sponsor: CHSO

Program Lead: Dawn Fania

Year Program Started:

Target Population:

Community Partners/Agencies:

Impacted (intended or actual):

INITATIVE

In Palliative Care Unit, new activity kits are helping children deal with impending loss of a loved one helping children work through their grief when someone significant in their lives is near the end of life. The Palliative Care Council initiated the idea of creating the resource kits as part of an effort to ensure the palliative care team is providing space and opportunity for play and recreation for children and youth. Included in the kit are items like the Game of Hearts to help children cope with their feelings, craft projects such as card making kits, and the book Waterbugs and Dragonflies which helps to explain death. The activities in the kit can be done independently by children or with the guidance of adults.

One of the most powerful tools in the kit is 'Your Story' which provides an outline for the child to interview their loved one in palliative care. The interview questions include such questions as: tell me about your favourite foods, favourite songs and tell me a story about you and me. Through this interview the children capture memories to comfort them in their time of loss, and to treasure for the rest of their lives.

ORGANIZATION: St. Joseph's Health Care Society

Sponsor: CHSO

Program Lead: John Denstedt

Year Program Started: 2017

Target Population: Residents of Port-au-Prince

Community Partners/Agencies: Project Haiti

Impacted (intended or actual): 16 during his visit, countless others as doctors perform the techniques they learned from Dr. Denstedt

INITATIVE

Invited by Project Haiti, a non-profit organization dedicated to medical care and education, Dr. John Denstedt, urologist, imparted his wisdom to a clinical team in Haiti while performing the country's first non-invasive kidney stone removal.

Dr. Denstedt spent seven days at St. Francis de Sales Hospital in the center of Port-au-Prince, one of several hospitals impacted by the magnitude seven earthquake in 2010, teaching enthusiastic Haitian physicians non-invasive urological techniques, Dr. Denstedt skillfully operated on 16 people in need of care. His efforts galvanized the Haitian physicians, one remarking that Dr. Denstedt's teachings "have revived us and created between us Haitian urologists a spirit of togetherness and team work that will help us get better faster."

Spending almost all of his time in the operating room, Dr. Denstedt performed four ureteroscopies with lithotripsy (kidney stone fragmentation) and 12 percutaneous nephrolithotomies- the removal of a kidney stone through a keyhole incision. Included in the 12 was the country's first kidney stone removal using a minimally-invasive method .The medical teams in Haiti have never been taught these procedures first hand. The goal of his time was to begin to introduce these techniques, work through their specific equipment and health care system challenges and have them utilize the techniques by using what they have.