Presenters

* Nalini Pandalangat  
  Lead HASJT, Director – Newcomer Health, Sherbourne Health Centre

* Criss Habal-Brosek  
  Partner & Steering Committee Member HASJT  
  Program Director, Progress Place

* Nivedita Balachandran  
  Health Promotion & Systems Specialist, Sherbourne Health Centre
## Presenter Disclosure

**Presenter:** Nalini Pandalangat

**Relationships with commercial interests:**

- **Grants/Research Support:** None
- **Speakers Bureau/Honoraria:** None
- **Consulting Fees:** None
- **Other:** None
**CFPC Conflict of Interest**

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## Presenter Disclosure

**Presenter:**  Nivedita Balachandran  

**Relationships with commercial interests:**

- **Grants/Research Support:** None
- **Speakers Bureau/Honoraria:** None
- **Consulting Fees:** None
- **Other:** None
St James Town

* 19 apartment buildings- TCHC and Privately owned
* One of North America’s most densely populated area, ¼ km²
* +19000 residents
* +40 different languages
* +100 countries
* Higher % of people of Aboriginal origin than rest of Toronto (2006 census)
* +65% newcomer/immigrant

Newcomer groups:
* Filipino, Nepali, Tamil, Somali, Chinese, Korean, Indian, Eritrean, Ethiopian
Urban Heart@ Toronto report (Feb 2014)

* Poverty and unemployment
* High rates of Diabetes
* High rate of ER visits & preventable hospitalizations
* Prevalence of mental health and addictions
* Safety concerns
* Significant number of seniors living alone
* Multiple marginalizations

Richly diverse, vibrant, engaged citizens, ingrained sense of collective responsibility
Health Access St. James Town

* 2010 Fire at 200 Wellesley St. – TC LHIN explored:
  * High-needs, high-risk residents not connected to care in meaningful ways
  * Services/resources exist in community
  * Different approach to integrating and coordinating health services
  * Built on evidence linking poverty, immigration status and other social determinants to a lack of access to needed services and poor health outcomes
Establishing neighborhood based, client focused model of integrated, collaborative care through inter-sectoral service coordination, service enhancement and community development

Improve service access and utilization to those most in need of health care and allied services (Via Intake Workers and active, targeted partnerships)

Promote overall health and well being through community engagement
Model of Community Based Care

Community outreach and engagement

Inter sectoral service coordination

Multi-sectoral Service Access

Client & Community Better health & SDH outcomes
Health Access Working Group
Partners: (2015)

* Anishnawbe Health Centre
* Community Care Access Centre
* Central Neighborhood House
* Community Resource Connections Toronto
* Dixon Hall Neighbourhood Services
* Hospice Toronto
* Progress Place
* Sherbourne Health Centre
  * Lead Agency
* St. James Town Community Corner *Service Hub
* Thorncliffe Neighborhood Office
* Toronto Community Housing
* Toronto Public Health
* Women’s Health in Women’s Hands CHC
An inclusive neighborhood based, community focused model of integrated care

achieved through

Onsite inter-sectoral collaboration, community development and a seamless service provision

“Owned by nobody” yet “owned by everybody”
St James Town Community Corner
200 Wellesley St. East

History

2005
- St James Town Service Providers

2006
- Community Assessment: 16 focus groups

2007
- Interim Steering Committee created: 8 residents + 5 agencies
- SJTSP Working Group (14+)

2008
- Recommendations:
  1. Settlement Services
  2. Health Care
  3. Meeting Space

2011

2013
- Expansion
- Grand Opening
St James Town Community Corner
200 Wellesley St. East

- Primary Site for HASJT Intake
- Gathering space for St James Town Residents

**Services Offered:**
- Medical Clinic
- Diabetic Support
- Mental Health/Addictions Counselling
- Family Counselling
- Newcomer Settlement Services
- Employment Services & Support
- Housing Support
- Group Sessions:
- Seniors Day Program
- Support group for Addictions and mental health
- Afterschool Programs:
- Social Activities
- Support Services
- Young Women/Men’s Circles
- Language learning support: English, French, Spanish, etc.
- Cultural Events and gatherings
- Pet food bank
Additional Community Supports that Health Access refers to:

- Dental Clinics
- Primary Care
- Personal Support Workers
- Senior Support Services
- Children’s Recreational Programs
- Meal Programs
- Income Support
- Information
- Adult Day Programs
- Culture Specific Groups
- Support During & After Pregnancy
- Etc…
**Health Access St. James Town Elements**

* Strong Partnerships - Inter-sectoral Service Collaboration

* TC LHIN – funds, supports and engages very meaningfully in the process

* Standardized Intake & Warm transfer mechanism – HASJT intake & point people at referral receiving partner organisations

* Hub based approach - Rooted in the St James Town Community Corner

* Outreach for access - Mobile intake sites for enhanced access, community ambassadors

* Collective Identity (Intake Workers/Community Corner)

* Holistic Data capturing mechanism – ongoing data refinement & analysis
Partnerships

- The Health Access Working Group forms the Steering Committee of the Project – ongoing review, planning, joint proposal development
- Health, Social Service Partnerships – local and city wide
- Progress Place and The Corner – Key partners in program implementation
- The Seniors Mental Health Day Program led by Progress Place in partnership with other senior serving organisations - well integrated with HASJT
Integrated Service Model
one-to-one and group services

The Corner
HASJT

Community led programs

Children and Youth
Primary Health
Mental Health
Diabetes Clinic

Settlement
Employment
Seniors Day Program
Case Management
Data at The Corner – A typical month
August 2014

Total New Intake & Referrals: 51
New clients accessing more than one service: 23
Counseling, Diabetes & Primary Care: 17
Dental: 5
Settlement & Employment: 15
Housing: 10
Seniors Day Program: 7
SJTCC run programming: 30
Intake Workers

* Intake Workers help residents connect with supports and services in the community
* Facilitate access to services in a timely manner by working with partner organisations and others
* Follow-up on service delivery
INTAKE WORKERS IN THE St. James Town COMMUNITY CORNER and community sites:

- Local Shelters
- Parenting Centres (Public School)
- Native Centres (in process)
- Seniors Groups
- Buildings
- Working with Community Partners (e.g. The STOP, TCHC, Growing Together, Community Matters)
# Health Access St James Town – Standard Referral Form

**Fax Number:** 416-964-6658

**Today's Date** | **Staff Name** | **Contact #**
---|---|---

**Current Time** | **Agency/Hub Name**
---|---

We need your permission to collect your personal and health information, and we may need to share this information with our staff and/or partner organizations (in order to be able to assist you in making a referral/connections to the services you need). Your information is private, and unless required by law, we will not share your information with anyone else without your permission. Do you give consent to this?  

**Client's initials:**  
**Consent? (Y/N)**

## Client Information

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Gender</th>
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<tr>
<th>Tel</th>
<th>OK to leave a message? Y/N</th>
<th>Alternate Tel</th>
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<tr>
<th>Address</th>
<th>Postal Code:</th>
<th>Intersection</th>
<th>Country of Origin:</th>
<th>Number of Years in Canada:</th>
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<tr>
<th>Type of Housing</th>
<th>Toronto Community Housing (TOH)</th>
<th>Market Rent Unit</th>
<th>Own/Bought Unit</th>
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<th>Temporary Address</th>
<th>Shelter</th>
<th>Other</th>
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<tr>
<th>Living Situation</th>
<th>Lives Alone</th>
<th>Lives with Others:</th>
<th>☐ Extended Family</th>
<th>☐ Immediate Family</th>
<th>☐ Other</th>
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<tr>
<th>Income Source</th>
<th>ODSP</th>
<th>OW</th>
<th>Full-time Employment</th>
<th>Part-time Employment</th>
<th>Relief Work (specify):</th>
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<th>Primary or Family Physician (name and tel)</th>
<th>Are you on a 3-month wait for OHIP?</th>
<th>Do you have any other coverage?</th>
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<th>Do you have an OHIP Number?</th>
<th>Y / N</th>
<th>Y / N</th>
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<th>Immigration Status</th>
<th>☐ Permanent Resident</th>
<th>☐ Convention Refugee</th>
<th>☐ Refugee Claimant</th>
<th>☐ Canadian Citizen</th>
<th>☐ Work Permit</th>
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<th>Preferred Language of Service</th>
<th>Special Instructions for Calling</th>
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**Comment:**

## Alternate Contact

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<th>First Name</th>
<th>Last Name</th>
<th>Tel</th>
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<th>Relationship</th>
<th>Comment</th>
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## Client's Reason for Accessing Support

**Primary Reason for Accessing Support:**  
**Related Health (or Other) Complaints:** Physical Health: __________ Chronic Disease: __________  
Mental Health: __________ Other: __________

## Referral Source

<table>
<thead>
<tr>
<th>Self-Referral (Phone / Walk-In)</th>
<th>CCAC</th>
<th>S purified Family</th>
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<tr>
<th>Another Service Providing Agency</th>
<th>Family Physician</th>
<th>Friend or Neighbor</th>
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<tr>
<td>Specify:</td>
<td>Hospital</td>
<td>Other (explain):</td>
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<th>Other (explain):</th>
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Services Requested
Please Specify: (e.g. Primary Care, Settlement, Dental, Adult Day Program)

I have informed the client that some of these services may not be covered by OHIP and subsidies may or may not be available

If Employment/Training/Education Services Requested, please complete

<table>
<thead>
<tr>
<th>Level of Education:</th>
<th>College/University</th>
<th>Secondary/High School</th>
<th>Elementary/Junior High School</th>
<th>None</th>
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<tr>
<td>Interested in:</td>
<td>Job Search/Resume Skills Development</td>
<td>Professional Job</td>
<td>Transition Job</td>
<td>Placement/Internship</td>
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Referral

Use Warm Transfer practices to complete a referral. Warm transfer begins by identifying the appropriate target agency, calling the agency and faxing this intake form. Once receipt of the referral is confirmed with the target agency, the warm transfer is completed by calling the client to confirm service is being arranged/delivered.

With your permission, I will ask another agency to contact you to arrange the service(s) you need. Do you give consent to this?
Consent? (Y/N)

Agency referred to for service

<table>
<thead>
<tr>
<th>Target Agency</th>
<th>Staff Name</th>
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<tr>
<td>Service(s) Required</td>
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<tr>
<th>Date agency called</th>
<th>Time agency called</th>
<th>Date transfer confirmed with Client</th>
<th>Time transfer confirmed with Client</th>
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<tr>
<td>Comment</td>
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23 ambassadors representing the diverse neighbourhood

Representing the buildings

Training and orientation completed

Access points to connect to intake and services at The Corner

Outreach for health promotion – flu shots, cervical cancer screening

Will benefit from relevant skill building and training
Community Engagement
Hearing, Reporting & Planning with...
57 Year old Female

- Aboriginal, hearing impaired: lip reads, unemployed, lives alone, family separated at young age and has minimal contact, isolated, hygiene/clutter problem
- CRCT Health Promoter referred to Seniors Program at the Corner
- No Phone- requested consent for home visit if needed- Consent given
- Mental Health- has deep anger and frustration at the world and stated that she would not hurt anyone but did not know how to deal with these feelings
- Referred to counselling
- Missed first appointment for mental health intake at Sherbourne, Intake workers had to do home visit- slipped reminder notice for next appointment
- Missed that appointment as well, attended another home visit
- Intake worker walked client over to the agency to have intake done
- Client attended sessions and positive feedback
- Follow ups are ongoing to ensure the counselling sessions are still being upheld as client sometimes does not attend
- This led to a CASE conference involving: Client, Family Services case worker, Catch-ED worker and Intake team: Looking for collaborative approaches to benefit client
64 Year old Male

* Referred by TCHC Resident Coordinator.
* Joint home visit: TCHC and Intake
* Isolated senior. Lived in rooming house for over more than 20 years.
* Has not filed income tax for a decade- possibly affecting benefits received.
* Has been to the emergency more than five times within a year.
* Connected to Catch ED – COTA case Manager through joint home visit (Cota&Intake)
* Intake has connected him to free tax clinic days through TNO
* Wanted to take computer classes
* COTA motivating him to attend programs:
  * Now attending computer classes
Data Capturing

- Investment by lead organisation in part time data personnel
- Collaboration with The Corner to develop a holistic data base
- Ongoing refinement of data capturing mechanism – very clear parameters for capturing high needs
- Ability to generate data that captures and reports referrals to partner organisations – integral in partnership review and planning
- Swipe system implemented and currently being piloted
Data overview
2014-2015

* Residents with high needs, complex care issues in TCHC who were connected to care – 94
* Unattached newcomers to SJT and other unattached residents with significant needs that were connected to care – 198
* Total number of warm transfers to referral receiving organisations – 452
Evaluation

- Partnership with the Evaluation Centre for Complex Health Inequities – Li Ka Shing Institute – St. Michael’s Hospital
- Process and outcome evaluation undertaken
- Evaluation team provides ongoing consultation and support to the process