in focus profile

CRNCC
Canadian research network for care in the community

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Leading knowledge exchange on home and community care

The CRNCC is supported by funding from the Social Sciences and Humanities Research Council of Canada (SSHRC) and Ryerson University.

Profiling *Solutions – East Toronto's Health Collaborative*: A Hospital-Community Collaboration Success

Background

Solutions- East Toronto's Health Collaborative (Solutions) is a voluntary network of a full continuum of health care organizations. Since 2001, it has been working collaboratively to create a coherent, integrated, coordinated system of care and support for the people of South East Toronto. Partner organizations in ***Solutions*** include Bridgepoint Health, Community Care East York, Neighbourhood Link Support Services, Nisbet Lodge, Partners for Health, Sherbourne Health Centre, South East Toronto Family Health Team, South Riverdale Community Health Centre, Toronto Central CCAC, Toronto Public Health, WoodGreen Community Services and Toronto East General Hospital.

The South East Toronto Community

Solutions members collectively serve a diverse population of over 300,000. A significant number of residents are immigrants to Canada and the top languages spoken, apart from English, are Cantonese, Greek and Tamil. The proportion of children in the community is growing, primarily in neighbourhoods where many new immigrant families reside, and the significant senior population is anticipated to increase in the near future. Within the community there are sizeable numbers people who are vulnerable due to low-income, lower levels of education, insufficient housing and mental health issues.

Shared Goals

- Preventative community care approach to continuing care;
- dignity and independence;
- comprehensive continuum of care;
- early intervention;
- home support;
- self-managed approach to care (if client is capable) to promote consumer choice, family control and independence;
- managed care transitions to assist clients as they move to, or through different care settings;
- supplementing provincial and community programs.

The Community Referrals by EMS (Emergency Medical Services) (CREMS) Project, the Community Rounds Project and the MRSA Clinical Protocol Educational Kits are examples of this network's successful outcomes.

Community Referrals by EMS (CREMS) Project

In 2005, ***Solutions*** developed the Community Referrals by EMS (CREMS) project to optimize the use of resources already existing in the system by providing paramedics with a new option to engage other health providers in serving at-risk people in the community. Traditionally, EMS response has been limited to administering medical treatment and either leaving the individual at home or transporting them to the hospital. The CREMS model provides a third option. Through a 24/7 information line staffed by the Toronto Central Community Care Access Centre (CCAC), a paramedic can make a community referral and

the CCAC will coordinate a needs assessment and links to community health and support services. This low cost innovative solution resulted in more appropriate use of EMS services and Toronto East General Hospital emergency department resources, giving people the right care in the right place at the right time. (http://www.tegh.on.ca/bins/content_page.asp?cid=8-1621&lang=1)

In April 2006, The Ministry of Health and Long Term Care presented ***Solutions*** with the Minister's Award in "Innovation for Meeting Community Needs through Integrated Care" for the CREMS project.

CREMS is currently being rolled out LHIN-wide by the Toronto Central CCAC and EMS and is being adapted by other hospitals and jurisdictions.

The Community Rounds Project

The Solutions network designed the Community Rounds Project (2005-07) to explore the factors that would facilitate successful transition from hospital to home. Specifically, the project aimed to:

- improve communication and collaboration between the hospital and community service sectors in South East Toronto/East York;
- pilot test a Common Assessment Tool (CAT) to be used by both hospital and community service providers;
- assess the health and social service needs of senior patients when they were being discharged;
- identify gaps in their health and social services needs at discharge; and,
- examine the reasons for those gaps.

Information was collected from 118 seniors who were admitted to TEGH during a 5-month period during 2006. Information collected included client's health status, service needs and the service referrals and recommendations proposed by the assessor. After one month, a follow-up survey was conducted on services that were or were not used.

Project results confirmed that discharge planning would benefit from improved coordination between hospital and community providers particularly in providing integrated care to vulnerable and isolated seniors living in the community.

The project also pointed out that those who were socially isolated, living alone, non-English speaking or required home modifications to enhance mobility were more likely to face greater challenges in their ability to live independently and to manage their care effectively after hospital discharge.

The study will be used to inform ***Solutions'*** participation in the LHIN-wide roll-out of the Home-at-Last (HAL) project. (http://www.crncc.ca/documents/CommunityRoundsResearchProject.pdf)

The East York MRSA (Methicillin Resistant Staphylococcus Aureus) Community Treatment Protocol

TEGH was an active member of the East York MRSA Community Protocol Group. The group also included Bridgepoint Health, Calea Limited, Comcare, Community Care East York, Coram Health Care, East York Access Centre, Flemingdon Health Centre, Ina Grafton Gage Home, KCI Medical, Leisure World Scarborough, Partners for Health, Spectrum Health Care, St. Elizabeth's Health Care, Suomi Koti, Therapy Supplies and Rental, Toronto CCAC, Toronto Public Health, Visiting Homemakers Association and VON.

A key purpose of this group was to develop communication tools that could be shared across all sectors on preventing the spread of MRSA, a major cause of serious infection

among the elderly and those with weakened immune system.

The result was a simple and effective kit designed to ensure a seamless continuum of care for MRSA clients in South East Toronto. Materials developed included:

- information for community practitioners and a community pathway describing treatment and infection control guidelines to be followed by all health sectors;
- an information handout for patients and families to facilitate client teaching;
- an MRSA Client Card which serves as the basis for tracking the treatment and monitoring of MRSA patients at all levels of the system.

(http://www.crncc.ca/documents/CommunityTreatmentProtocolforMRSA.pdf)

In 2003 the **East York MRSA Community Treatment Protocol** group partnered with the ***Solutions*** network to print and disseminate **MRSA Clinical Protocol Educational Kits** for community organizations. ***Solutions*** then funded training to help front-line workers from local agencies use the protocol. Many institutions from across Canada have also requested copies of the kit.

Lessons Learned: Foundations of Successful Partnership

What does it take to develop a successful ongoing partnership? According to ***Solutions*** members, critical success factors include:

- systems thinking, shared vision, clarity of language and common goals;
- investment of time to develop good working relationships and trust;
- clear and open communication, with a respect for diversity;
- shared accountability and contribution;
- consistent organizational commitment;
- ample collaborative planning time;
- sustained and adequate resources; and,
- measurement and evaluation of outcomes.

So what?

This Profile illustrates how hospital and community health providers have collaborated over time to make the best use of local knowledge, skills, resources and capacities to provide a continuum of services for vulnerable populations in their shared catchment area. Solutions continues to devise innovative strategies that make the best use of available resources to maximize integrated care for individuals and cost benefits for the broader health system.

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Last Edited

August 2010