POLYCULTURAL
IMMIGRANT & COMMUNITY SERVICES

After the Discharge Project:

Summative Evaluation

For for Polycultural Immigrant & Community Services

March 2017

Completed by Nicole Pietsch

Introduction:
About the *After the Discharge* Project

Polycultural Immigrant Services & Community Services meets the needs of diverse communities in Metro Toronto and the Regional of Peel. The agency offers a wide range of services and programs for newcomers to Canada, including specific programming to meet the needs of adults, youth and seniors. Services include newcomer orientation & citizenship test preparation, settlement counselling, language training, career exploration & employment assistance program, community referrals and various psycho-social wellness programs[1].

The *After the Discharge* Project was developed by Polycultural Immigrant Services & Community Services with an awareness that a significant service gap existed in linking senior and marginalized populations to available community programs upon their exit from the hospital. The Ontario Trillium Foundation funded a project grant for *After the Discharge*. This is an innovative project, planned and delivered at the conceptual stage, and including a pilot service targeting the identified population. The project is delivered in partnership with William Osler Health System. Building inclusive and engaged communities, this initiative aims to help people who are isolated to have connections in their community, particularly connections which continue support of their social and health needs.

The goals of the project are to develop, launch and test the new project.

The objectives (deliverables) of the overall project are to:

1. Develop a partnership model between a hospital and a community agency that provides continued support to seniors and marginalized groups after their discharge
2. Provide client-centered support for continuum of care to members of these two groups discharged from the hospital
3. Provide culturally and linguistically appropriate services
4. Promote independence and well-being of the program participants through connection to local community resources for physical, mental, emotional and social well-being
5. Support the philosophy/work of Health Links, which has a focus on the Social Determinants of Health for complex patients.

At its outset, the project intended to have an impact on the lives of 150 people in the community.

The grant under the OTF Seed Investment stream supported the project for one year from April 1, 2016 to March 31, 2017. An external Evaluator has applied a consistent process of evaluation to the poject.

This Report offers a *Summative* evaluation of the overall project, including the piloted services to seniors following their discharge from the hospital.

[1] Polycultural Immigrant & Community Services. *What We Do.* Online: http://www.polycultural.org/what-we-do

What is being Evaluated in this Report?

An external Evaluator has applied a consistent process of evaluation to the Project overall. Evaluation work included:

- Development of accessible program service-user evaluation tools for the Polycultural's *After the Discharge* project
- Facilitated staff orientation to and implementation of program service-user evaluation tools for the Polycultural's *After the Discharge* project
- Obtained completed survey data from Polycultural's staffs
- Obtained other Project (non-survey) data from Polycultural's staffs
- Survey project partners on their experience of the project's acheivements.
- Analyze met and unmet Project service-user targets
- Deliver a *summative* (that is, describing the impacts of the Project's piloted services to seniors following their discharge from the hospital) evaluation.

Evaluation data related to the Project were captured and assessed through the following Workplan/Critical Path:

Key Milestone/ Deliverable	Related Tasks	Estimated Task Completion Date
Project Start	Workplan approved	September 15, 2016
Develop Project evaluation tools	Development of program evaluation tools: • 1 service-user/Project participant tool • 1 survey for Project partners	September 15, 2016- December 30, 2016
Implement Project evaluation tools	Meet with Project staffs (Project Worker and Project Manager): • Facilitate staff orientation to program service-user evaluation tools • Offer best practice/tips for consistent implementation	January 6, 2016- February 15, 2017
Evaluation, service-user data	• Obtain collected data from PICS staffs • Analyze data resulting from completed program service-user evaluation tools • Analyze data from partners' survey	February 20, 2017
Report: Summative	Evaluation Report includes: • met and unmet Project service-user targets • impacts of the Project on service-users (from survey data and interviews) • partners' survey results and recommendations • Project achievements, other	March 15, 2017
Evaluation term end		March 31, 2017

In this report, the Evaluator will:

1. Deliver a *summative* evaluation of the Project. The Project *summative evaluation* queries:
    - Did the Project meet its stated goals and objectives?
    - Did the Project meet its targets?

In addition, the *summative* evaluation will identify:

- Achieved work, based on Project goals and objectives
- Recommendations for future work
- Recommendations towards Project/service sustainability

Summative Evaluation: **After the Discharge Project**

Did the *After the Discharge* Project meet its stated objectives?

The objectives (deliverables) of the overall Project are as to:

1. Develop a partnership model between a hospital and a community agency that provides continued support to seniors and marginalized groups after their discharge
2. Provide client-centered support for continuum of care to members of these two groups discharged from the hospital
3. Provide culturally and linguistically appropriate services
4. Promote independence and well-being of the program participants through connection to local community resources for physical, mental, emotional and social well-being
5. Support the philosophy/work of Health Links, which has a focus on the Social Determinants of Health for complex patients.

In addition, at its outset, the project intended to have an impact on the lives of 150 people in the community.

The above objectives progress towards the overall goals of the project, which are to develop, launch and test a new project of assisting seniors and marginalised after they are discharged from the hospital.

The Evaluation is conducted and analysed against these above criteria (objectives). This section of the report offers a *summative* evaluation of Polycultural Immigrant Services & Community Services' achievement of the above identified objectives connected to the *After the Discharge* Project.

Objective 1: *Development of a partnership model between a hospital and the community agency (of Polycultural Immigrant Services & Community Services) that provides continued support to seniors and marginalized groups after their discharge*

Polycultural Immigrant Services & Community Services meets the needs of diverse communities in Metro Toronto and the Regional of Peel. Today, the agency offers a wide range of services and programs for newcomers to Canada, including specific programming to meet the needs of adults, youth and seniors. Services include newcomer orientation & citizenship test preparation, settlement counselling, language training, career exploration & employment assistance program, community referrals and various psycho-social wellness programs[2]. Well aware of the socioeconomic pressures impacting newcomer populations in the region, most services are offered free of charge.

The *After the Discharge* Project was developed by Polycultural Immigrant Services & Community Services with an awareness that a significant service gap existed in linking the senior and marginalized populations to available community programs upon their exit from the hospital. While many health and community service exist in Peel region[3], no dedicated staff or

[2] Polycultural Immigrant & Community Services. *What We Do.* Online: http://www.polycultural.org/what-we-do
[3] See: Region of Peel. *Social Services.* Online: https://www.peelregion.ca/social-services/

program aimed to concretely link to recently discharged immigrant seniors, with the aim of fostering continued community-based care. Oftentimes, socially marginalized individuals and newcomer families are wary or inexperienced in enlisting support from outside (non-family) sources, face service access barriers (such as financial, language or transportation barriers), or lack awareness about what services exist to provide long-term case management support. In order to bridge these barriers, program staffs must be aware of barriers, and willing to take steps to mitigate them. With this in mind, Polycultural Immigrant Services & Community Services initiated the *After the Discharge* Project, which aims to help people who are isolated to have these connections in their community – particularly connections which continue support of their social and health needs.

In order to meet this goal, the Project could not be successful without the active participation of a referring hospital itself. This Evaluation finds that Polycultural Immigrant Services & Community Services has worked in consistent, collaborative and at times innovative ways to both initiate and maintain a partnership model between the hospital and themselves, the community agency.

An informal agreement between Polycultural and William Osler Health System was in place at the time of the project funding submission to Ontario Trillium Foundation. In January 2016, just prior to the initiation of the *After the Discharge* Project, Polycultural and William Osler Health System entered into a formal service agreement.

A Memorandum of Understanding between the two organizations committed to jointly promote the Project services. The Memorandum recognized the Project's objectives in providing:

- Non-clinical support services by Polycultural to William Osler patients from a diversity and equity lens
- Establishing partnerships with community settlement services (that is, Polycultural services) to be provided by professionals who are well-established in the settlement sector, and can provide culturally appropriate and language specific services;
- and outlining collaborative participation in the Project's Framework, specifically:
    - Referrals from Etobicoke General Hospital (a branch of William Osler Health System)
    - Telephone referral checks by Polycultural Project staffs
    - Friendly visiting by Polycultural Project staffs
    - Community referrals/connections, facilitated by Polycultural staffs[4].

The Memorandum of Understanding, in addition, outlines the day to day roles of both Polycultural and William Osler staffs in promoting, referring to and rolling out the Project services. See **Appendix A** for an outreach flyer/poster, outlining the *After the Discharge* collaboration and services.

This Evaluation finds that the partnership between Polycultural and William Osler has been successful in both introducing and fostering the *After the Discharge* Project in the community; as well as cultivating the community's engagement with the Project deliverables.

As a result of the formal partnership, the Project saw referrals from the following organizations/health units:

[4] Dated January 26, 2016. *Memorandum of Understanding between Polycultural Immigrant Services & Community Services and Health, Equity & Inclusion/William Osler Health System at the Etobicoke General Hospital campus.*

- Geriatric Emergency
- Pre-admission
- Mental health, in-patient
- Mental health, Outpatient
- Physiotherapy
- Respiratory
- Site Division Head of Hospital Medicine
- Community Care Access (Outpatient/Post-discharge support)
- Palliative Care Program and Rehab
- Health Equity and Inclusion

The Project saw referrals and Project information outreach/dissemination from the following staff positions:

- Registered Nurses
- Registered Practical Nurses
- Social Workers
- Day Surgery Nurse
- Discharge Coordinator
- Discharge Planners
- Recreation Therapist
- Doctor/hospitalist
- Case Manager
- Diversity Projects Coordinator[5]

The partnership between these health departments/professionals and Polycultural resulted in 54 clients (referred seniors) to date, plus an additional 25 secondary (family members) service users, to make 78 users in total.

This Evaluation finds that partner agencies, partner health departments and referring staff all report positive interactions and experiences with Project activities, including their understanding of Project services, interactions with Project staff, and their interest in connecting service-users (clients) to the service. In a Project partner survey, 100% of health professionals from the William Osler Health System who completed the survey identified that they *strongly agree* or *agree* that they are aware of the Post-Discharge service and how it can benefit patients. 100% of health professionals who completed the survey also identified that they *strongly agree* or *agree* that it was easy to refer patients to the Post-Discharge service.

Moreover, 100% of health professionals who completed the survey identified that they *strongly agree* or *agree* that they recommend this service to patients or other health Professionals.

Survey respondents also shared the following comments:

- *"When I do bring it up [the Project and service description] patients are very excited about the service"*
- *"It's great that this service is able to see many different types of patients"*
- *"Thanks for your ongoing efforts to help Osler patients."*

[5] Polycultural's management staff and *After the Discharge* Project staff participated in the collection and conveyance of this data.

It is worth noting that the partnership contributed to William Osler Health System's recognition for achievements in innovative partnerships with community organizations (see **Appendix B**) in 2016.

In addition, Polycultural received two endorsing letters of support from William Osler System staff who participated in the Project's pilot services, and representing different health/hospital departments: Adult Mental Health and Rehabilitation Unit of Etobicoke General Hospital. Notable feedback includes the following:

- "*linking discharged patients to community resources is a vital component to their successful reintegration. The Polycultural Immigrant and Community Services- Post Discharge Services provide this much needed service"* (Social Worker, Adult Mental Health)
- *"our patients are discharged from the hospital home with many concerns and anxieties. Having a strong community program such as the Post-Discharge Services allows our patients to transition home, understanding that support may be available to them, and the extra reassurance of regular reassurance checks"* (Recreation Therapist, Rehabilitation Unit)
- "*Friendly visiting provided through the program…can prevent future readmissions"* (Recreation Therapist, Rehabilitation Unit)

To read the letters in full, see **Appendix C.**

Last, Polycultural shares that while the Project originally targeted partnered work with Etobicoke General Hospital (and achieved this), the partnership was expanded to reach the St Joseph Health Centre in 2017 as well. This is a strong indicator of the Project's success in meeting Objective 1.

Objective 2-3: *Provide client-centered support for continuum of care to members of those discharged from the hospital; Provide culturally and linguistically appropriate services*

Peel region encompasses 1.3 million residents in Brampton, Caledon and Mississauga. Owing to immigration and its transportation infrastructure, Peel Region is a rapidly growing area: the region is the second-largest municipality in Ontario after Toronto[6]. Notable as well, the Region of Peel notes that over 56% of the population self-identify as a visible minority (racialized) person in Peel: this is significantly higher than Ontario's (25.9%) population overall[7].

As a community-based multi-service newcomer agency, Polycultural Immigrant Services & Community Services leadership, staff and volunteers have expertise about the existing needs of the community members they serve. Organizational programming reflects these needs, as well as a clear understanding that social location has an impact on one's everyday experiences – including access to medical, health and social supports.

Regional examples of the connections between health and social location include the following realities:

[6] See: Toronto Vital Signs 2013. *Toronto's Shifting Demographics*. Online: https://torontofoundation.ca/torontos-vital-signs-report-2013; and Region of Peel: https://www.peelregion.ca/overview.htm
[7] Region of Peel. *Quick Stats: Visible Minorities.* Online: https://www.peelregion.ca/health/statusdata/pdf/ethnicity-c.pdf

- There are more than 90 languages spoken in Peel region[8]. While this is a reality for many newcomers to Canada, settled immigrants and seniors, most social services, public services and outreach strategies in Peel are largely presented in English
- Health ailments such as diabetes, arthritis, heart and stroke disease and dementia affect the aging population, limiting their independence, quality of life, and capacity to connect socially with others. Certain health concerns affect ethnic populations in greater numbers[9]
- Nearly 40% of Peel seniors live in poverty[10].

Polycultural Immigrant & Community Services is well aware that these social elements impact the health and psycho-social wellbeing of immigrant seniors in the local community. Moreover, these social contexts can inadvertently create service barriers to highly isolated community members, in particular, seniors.

The *After the Discharge* Project was developed with an awareness of these concerns and how they may specifically impact older populations of immigrants in Peel, as well as their family members. In response, the Project aims to approach service-users with client-centered support for continuum of care. A client-centred approach often necessarily included providing culturally and linguistically appropriate services within the context of the Project.

In an interview with this Evaluator, the *After the Discharge* staff Project Lead identified the following ways in which client intake/assessment, intervention and referrals to additional supports incorporate a client-centred framework:

I. Intake and Needs Assessment

The client intake to *After the Discharge* services consists of a needs assessment which queries the current state of the client's healthcare, housing, financial, personal care, mental health, language learning and ethnic community, and social and recreational needs. The needs assessment is facilitated by phone by the Project Lead after the hospital referral arrives. Where needed, needs assessment interviews occurred in-person with the service-user at the hospital, and with the support of a Polycultural Immigrant & Support Services settlement worker, who spoke the language of the service-user.

Oftentimes, families and individuals leaving hospital are overwhelmed with forms they are required to fill out or sign, as well as information they receive about follow-up care. The Project Lead ensures that she describes who referred the client (senior service user) to the *After the Discharge* program; describes what services it includes and how a person may benefit from these; and differentiates it from other services or care -- for example, personal support worker or nurse.

The needs assessment helps to identify client needs and to build a rapport with the client and their family members. Access barriers (for example, lack of financial resources, language interpretation needs) are also identified throughout this process, creating a client-centred plan.

[8] Peel Regional Diversity Roundtable (RDR). *Why Peel?* Online: http://www.dicharter.rdrpeel.org/about-us-our-story/
[9] See: Canadian Ethnocultural Council. 2013. *A Community Guide on Diabetes in Immigrant Ethnic Populations: Sample Programs for Early Detection and Management,* p. 3-4
[10] Ibid

II. Intervention

If the client agrees to see a Friendly Visitor at their home, the Project Lead facilitates a Friendly Visitor match based on the client's identified needs, language, age, location and other factors, as needed.

The Friendly Visitor conducts the first visit, then writes a report on the first visit and submits it to the Project Lead. The report can identify further needs, barriers and goals identified by the client or their family members.

The Project Lead ensures to follow-up with the client after the first visit, to ask if the Friendly Visitor was helpful and a good match.

As per the Project framework, the Friendly Visitor conducts visits once per week, for up to three months. However, some clients require less visits; and some have required more (for example, twice per week in the beginning). Languages spoken by Friendly Visitors and Polycultural settlement staff who support Project service delivery include Punjabi, Urdu, Polish, Italian, Tamil, Tagalog, Russian, Ukrainian, Pawta, Arabic, Kurdish, Albanian, and Hindi.

III. Referrals

Referrals to community, social and other supportive services are based on needs identified by the client or their family members.

The Project Lead has local expertise about existing community resources and programs to meet needs; and also maintains awareness of organizations that have expertise and programming that targets specific cultural or ethnic populations, or offer services in a variety of languages. Aware that social location such as race, religion, age and gender, can impact service-users' counselling or support options, the Project Lead also maintains expertise on immigrant-serving or ethno-specific organizations that offer targeted services for women facing particular concerns, health or social issues.

Referrals that have been made for clients (seniors) and secondary clients (family members) are as follows:

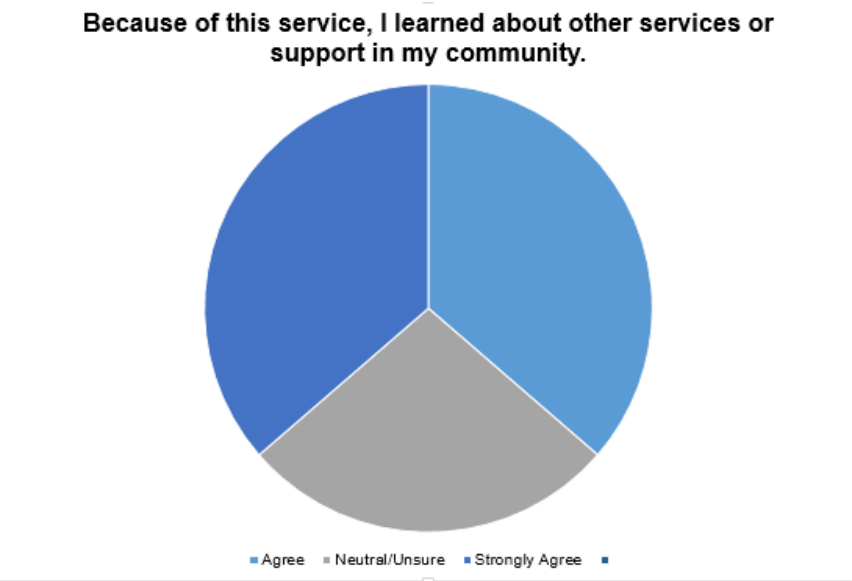
- Culturally relevant parenting skills groups
- Language specific mental health counselling and case management (predominantly Hindi, Punjabi, Tamil and Urdu) at Brampton Multicultural Centre, Rexdale Women's Centre and Rexdale Community Health Centre
- Senior programming (gentle exercise and social clubs) at Islington Senior's Centre, Etobicoke Services for seniors
- Senior Crisis Access Line
- Diet and Culture specific food banks at Muslim Welfare Bank and Red Cross Food Bank
- Internal referrals: Polycultural settlement services and commissioner services
- Language classes and language assessments: YMCA
- Transportation services info : Wheel Trans, CANES[11]

[11] Polycultural's management staff and *After the Discharge* Project staff participated in the collection and conveyance of this data.

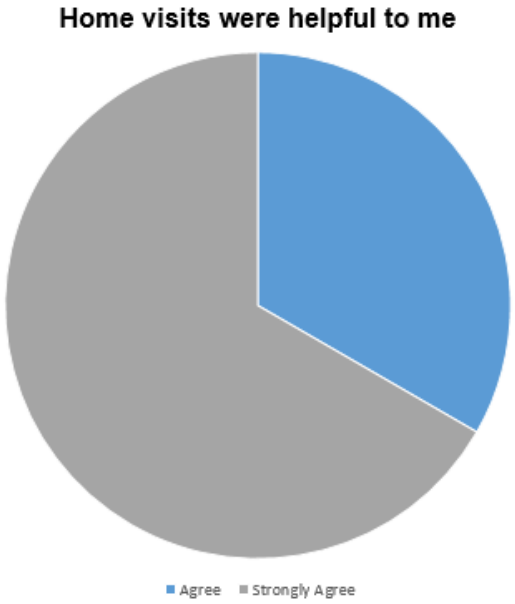
While *referral* to a service in the community traditionally suggests offering a brochure, phone number or general information about a service, the Project Lead notes that *After the Discharge* staff and volunteers augment this practice, intentionally bridging a client to the services he or she needs. This may occur by sharing detailed information with the senior about the referred service, calling the referred service while with the senior present, or completing an intake to the referred service during a Friendly Visitor visit. All of these practices help to facilitate a positive transfer to the new service, and offer a continuum of care approach. Opportunities to advocate for seniors facing service barriers can also occur where needed.

This Evaluation finds that this nuanced and social context-informed approach to implementing the Project services has supported service-user engagement. It has also helped to close service gaps in the lives of many Project service-users.

In a survey of seniors who had benefitted from the *After the Discharge* service, over 70% of those who completed the survey identified that they *strongly agree* or *agree* that because of this service, they learned about other services or support in the community:



Overall, all clients surveyed who had used the Friendly Visitor service either *strongly agreed* or *agreed* that home visits from a Friendly Visitor was helpful to them:



Rapidly changing demographics in a region – for example, a growing youth, aged or newcomer community, as seen in Peel region[12] – and the nuanced lived-realities and barriers experienced by these diverse populations are not always reflected in larger systems. Ideally, social services and community-based support systems recognize and meet the needs of those in their immediate, diverse community. Indeed, over half of all service-user survey respondents identified that Project services had been provided to them at their request in a language other than English. Overall, this Evaluation finds that the Project design, implementation and staff worked strategically to provide culturally and linguistically appropriate services

William Osler System staff who participated in the Project's pilot services agreed, offering the following comment about the Project's capacity to provided culturally-relevant and client-centred continuity of care:

- *"[the Project's staff] are able to meet the ethno-specific needs of [adult mental health] patients by providing services in the mother tongue of many of the patients. Their expertise in immigration and settlement issues provide valuable insights to some of the psycho social stressors many patient's struggle with which impacts on their Mental Health condition"* (Social Worker, Adult Mental Health)
- *"I have referred many patients to this program since it began, and truly feel it does make a positive impact in continuity of care"* (Recreation Therapist, Rehabilitation Unit)

Service users also identify that the program supports offered center around their needs. A 77-year old, living alone, made the following testimonial, after receiving services for three months:

[12] Peel region encompasses 1.3 million residents in Brampton, Caledon and Mississauga. Peel Region is the second-largest municipality in Ontario after Toronto. Owing to immigration and its transportation infrastructure, Peel Region is also a rapidly growing area. The Region of Peel notes that there are a high proportion of population who self-identify as immigrant and visible minority groups in the region (see: https://www.peelregion.ca/health/statusdata/pdf/ethnicity-c.pdf).

"I am so pleased to have [Friendly Visitor] Charlyn's visits every week. She is very polite and helpful by all means. I would like to have her visits twice a day because she really understands me and she respects me too…I have four children, but they are all abroad, I have no one around. Your program was very helpful for me."

Similarly, a 95-year old living with daughter who works full time, identified how contact from program staff decreased her isolation: "*I am thankful for the services I received. The friendly visits were very helpful and also receiving phone calls to check on me.*

This evaluation finds that *After the Discharge* successfully provided client-centered support and continuum of care to its service-users, as well as culturally and linguistically appropriate services.

Objective 4: Promote independence and well-being of the program participants through connection to local community resources for physical, mental, emotional and social well-being

In an interview with this Evaluator, the *After the Discharge* staff Project Lead identified the following health issues and social concerns commonly facing referred service-users:

- Heart conditions
- Chronic conditions, such as diabetes or arthritis
- Physical mobility challenges related to surgery, disability, aging or chronic health issues. Many primary service-users are not mobile
- Social isolation, caused by or in addition to physical health problems
- Mental health concerns, such as anxiety or depression
- Many are waiting for access to a day program, seniors housing, or intake into residential care
- Many senior clients are living with spouses, who also have health issues. In these cases, the Friendly Visitor often provides support and referrals to both
- Bereavement support for spouse, in the case that the client passed away
- Family members (secondary service-users) commonly present settlement needs that can be met by Polycultural or other regional services

Certainly, much research points to the interconnectedness of physical, mental and social health in populations and in individuals. The *After the Discharge* Project was designed and implemented with this holistic awareness concerning the many contextual and life components which can inform health and well-being.

In an interview with this Evaluator, the *After the Discharge* staff Project Lead identified a number of ways in which many non-clinical, however health-informing improvements – such as social support networks; education; improving social environments; fostering personal health practices and coping skills – resulted from service-user engagement in the Project services.

The Project staff identified the following ways in which the services promote independence and well-being of program participants:

I. Increases Service-User Confidence and Motivation

The Friendly Visitor offers opportunities to check-in with the service-user and his/her family, which increases the senior's confidence and motivation to improve one's health and day to day life after the hospital discharge. A Project partner identified similar impacts, sharing that: "Friendly visiting…helps our patients reduce the social isolation they may have been feeling at home prior to admission to hospital, and provides an opportunity to speak to someone about their health" moving forward (Recreation Therapist, Rehabilitation Unit).

II. New information leads to new opportunities

Friendly visiting can offer avenues to receive new information about existing service options, programming available to immigrant seniors, and activities that decrease both inactivity and isolation. This widens psycho-social options for seniors who may have previously been isolated, inactive or anxious about accessing external (non-family) means of social support.

The Project Lead notes that many senior service-users "begin to see that they can attend a program, go for a walk, or socialize with others," following their connection to a Friendly Visitor. "They establish a rapport with the Friendly Visitor, then can apply those relationship learnings with others in the community."

A female service-user identified that the Friendly Visitor's ability to present information about services and programs, and then support her to try out these options, made a significant difference in her life: *"I need to get out and socialize. That's easier said than done. However, [Friendly Visitor] Irena came equipped with the process [and the] number [to call for] recreational activities: …Fitness Programs available for seniors, ballroom Dance Club number and sharing a personal story of a person she knew…It is going to be a difficult for me to step out and take the risk but I feel confident with Irene's encouragement and follow up – I will do so!"* To read the complete testimonial, see **Appendix D.**

III. Project staff and volunteer advocacy can bridge service gaps

In addition to a lack of awareness about what services exist, immigrant seniors can face service access barriers -- such as financial, language or transportation barriers. In order to bridge these barriers, program staffs must be aware of barriers, and willing to take steps to reduce barriers on behalf of support service-users. This has been a strong component of the *After the Discharge* Project service.

The Project Lead notes that "if they [service-user] are willing to try something new, we can support them to access it [program, for example]".

Likewise, a Project health partner agrees, sharing the following: "Many of my patient's require hands on assistance with advocating for services, i.e. financial, legal, housing, employment, language and medical services, which the [Project] case manager is able to assist with" (Adult Mental Health, Social Worker).

One service-user identified shared the following success story about advocacy support from her Friendly Visitor's: *"I had forgotten to renew my disability claim form to claim the*

amount eligible in my case and was stunned to hear $1800 was what I had to pay while I was expecting a $300.00 refund. [Friendly Visitor] Irene directed me, guided me and what I believe now will be a successful solution." To read the complete testimonial, see **Appendix D.**

A 95 year old service-user agree that referral and advocacy made a difference in connecting her to community supports: "I am happy I was referred to this program and I got information about other day programs and what I need to do if I want to join them. I will be joining a day program soon."

This Evaluation finds that Project services have been successful in promoting independence and well-being of program participants.

Objective 5: Support the philosophy/work of Health Links, which has a focus on the Social Determinants of Health for complex patients.

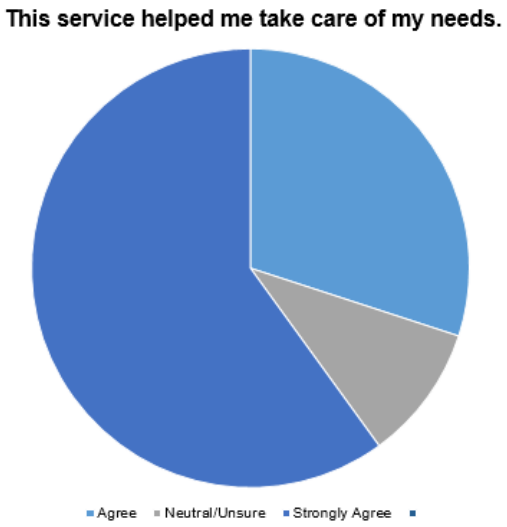
The *After the Discharge* Project maintains the philosophy/work of Health Links, which has a focus on the Social Determinants of Health for complex patients.

Canadian research points to the fact that spending more on health care *alone* will not result in significant further improvements in population health: On the other hand, there are strong and growing indications that other factors such as living, housing, social and working conditions are crucially important for a healthy population. Health Canada states that "evidence indicates that the key factors which influence population health are: income and social status; social support networks; education; employment/ working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture"[13].

This Evaluation finds that the Project services, particularly the nuanced referrals and service engagement facilitated by the Project lead and Friendly Visitor staffs, fostered an increase in the above-listed competencies in the lives of service-users.

90% of clients who completed the survey identified that they *strongly agree* or *agree* that the Post-Discharge service helped them to take care of their needs:

[13] See: Public Health Canada. *What Determines Health?* Online: http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php



In the context of the Project deliverables, service-user needs represent a range of necessities: physical health needs, social needs, mental health needs, or other practical needs such as housing, language instruction or settlement supports – all which the Project has recognized as relevant. Likewise, a senior service-user shares that the Friendly Visitor component of the program has "helped me mentally and physically". To read the complete testimonial, see **Appendix D.**

Overall, this evaluation finds that the Project achieved its stated objectives.

After the Discharge: Project Targets

A summary of these targets are noted below, and analysed in the following chart:

Project Targets are as follows:

- 150 seniors and marginalised individuals are supported by project activities
- Number of readmissions to the hospital within first month of the treatment is lower for project participants than the average statistics for the EGH
- Participants declare that they are well supported after the discharge and their needs are met though participation in community programs as a result of the project

	Project Target	Target-related Achievements	Achieved Participation
1.	150 seniors and marginalised individuals	• 54 primary clients (referred seniors) • 25 secondary (family members) service users, to make 78 users in total.	78 service-users users in total.
2.	Number of readmissions to the hospital within first month of the treatment is lower for project participants than the average statistics for the EGH	• 11 primary clients surveyed	All surveyed clients identified that they were *not readmitted to hospital* while receiving the Project services
3.	Participants declare that they are well supported after the discharge and their needs are met though participation in community programs as a result of the project	• 11 primary clients surveyed	90% of clients who completed the survey identified that they *strongly agree* or *agree* that the Post-Discharge service helped them to take care of their needs.

Polycultural and Project staff share additional contexts concerning service-user targets (1, above). The target of 150 service-users was ambitious for a short-term pilot.

In addition, staff did not anticipate that family members of primary service-users would also require referrals, support or direction in caring for their senior family member, or support for themselves. Last, primary and sometimes secondary service-users often required more advocacy, bridging to community services, check-ins and case management support than

anticipated. Many families identified that the three-months of Friendly Visitor support was not sufficient to meet the needs of service-users facing complex issues, such as wait-lists for appropriate housing, sustainable attendant care or day programming.

Project staffs and service-users alike recommend additional capacities for the program to meet these needs, such as a longer Friendly Visitor program (4-6 months instead of three) and a full-time case manager position at Polycultural.

With these contexts in mind, this Evaluator finds that the Project reasonably achieved all targets.

Recommendations

Prior to *After the Discharge,* a significant service gap existed in linking the senior and marginalized populations to available community programs upon their exit from the hospital. This Evaluator recommends that the Project and its services continue, where possible.

In addition, Project staffs and service-users made additional recommendations based on the Project's pilot, so to improve the service's organizational capacity:

- Offer a longer Friendly Visitor program (4-6 months instead of three)
- Case management was not a part of the original Project; in our learning, many families could have benefited from a case management support model. Staff recommend a full-time *After the Discharge* case manager position at Polycultural (the pilot Project's staff position is part-time)
- Follow-ups on the phone are also much appreciated by service-users. The social contact with another person makes a big difference for them. This expectation can be formally integrated into the Friendly Visitor or case manager's role
- Continue to communicate with hospital to promote the project to increase the number of referrals.

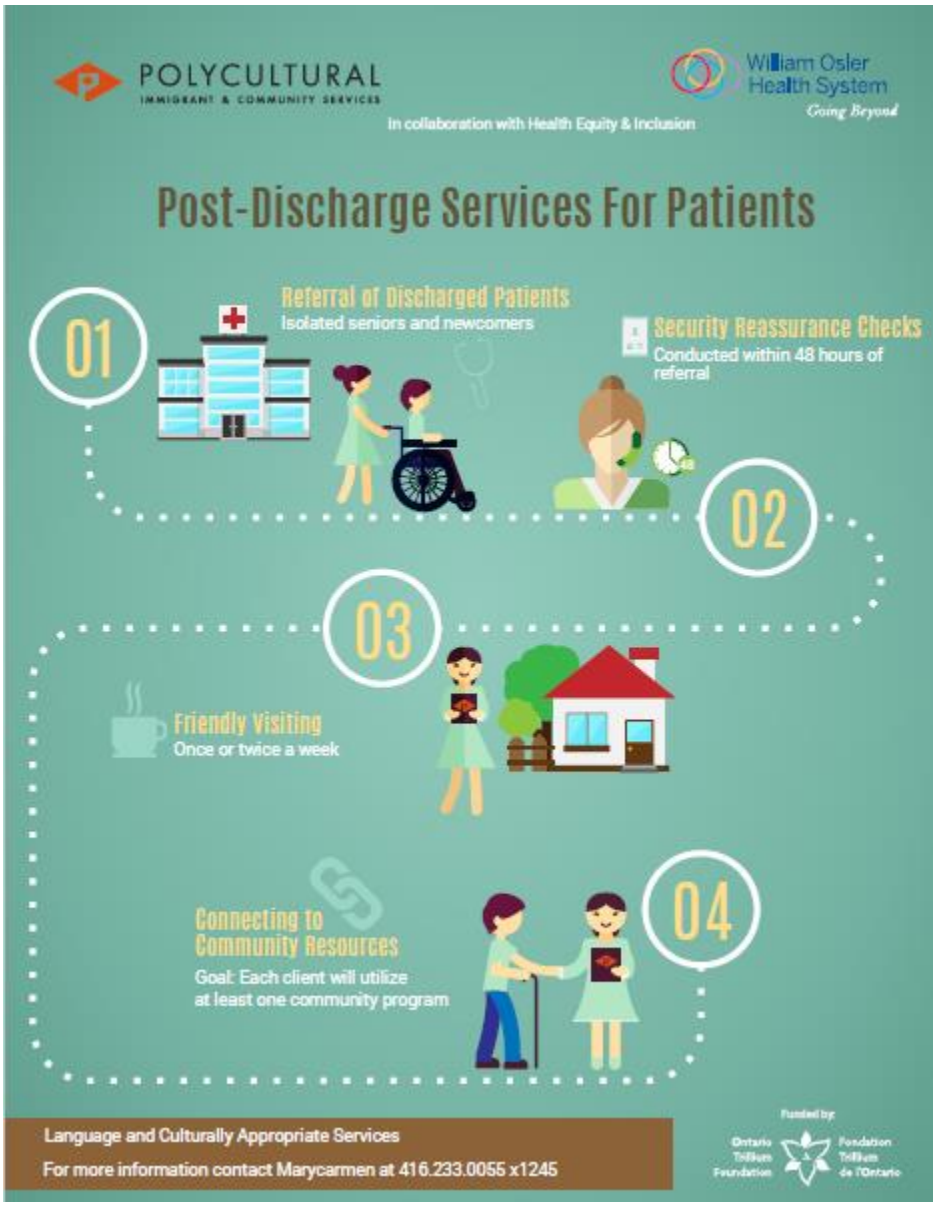
Sustainability

The Project and its piloted services intentionally produced foundational documentation, such as intake forms, program guidelines, comprehensive Friendly Visitor orientation materials, and health partner agreements. These resources will be helpful should Polycultural extend or reproduce these services in the future.

These documents and tools have also functioned to document the program's successes, including creating foundational resources and information that can support funding submissions for future work.

Polycultural Immigrant & Community Services may also explore possibilities for funding a longer-term or an ongoing *After the Discharge* program, which includes the recommendations identified above.

Appendix A: *After the Discharge* Outreach Poster



Appendix B: William Osler Health System, recognition for achievements in innovative partnerships with community organizations

William Osler Health System

November 8, 2016

Re: Announcement: Awards for William Osler Health System's Community Partnerships!

Dear Friend and Colleague:

I am pleased to share that William Osler Health System (Osler) has been recognized for achievements in innovative partnerships with community organizations:

- Accreditation Canada Leading Practice 2016: *'Cultivating Collaboration Across the Continuum of Care through Diverse Clinical and Community Partnerships'*
- Diversity Journal 13th Annual International Innovations in Diversity: *Award of Excellence 2016*

Since 2008, many valuable partnerships have been forged with the vision of providing excellent, equitable and barrier-free quality of care across the continuum. These partnerships have positively impacted the patient experience, clinical outcomes, patient health outcomes and the health system.

In recent years, we have signed five Memoranda of Understanding (MOU) with local agencies. These MOUs have yielded substantial benefits including:

- Faster discharges, reduced admissions and reduced unnecessary Emergency Department visits
- The provision of on-site settlement services, post-discharge services and qualified interpretation
- Connecting patients to language and culturally appropriate services including seniors' services, friendly visiting, reassurance checks and day programs
- Helping patients, families, staff and physicians to navigate the health system

Special thanks to the following with whom we have formal MOUs. They have been on-site providing services and support to patients, families, staff and physicians on a weekly basis. From June 2015 to date, these organizations have responded to over 1,200 enquiries:

- ***Polycultural Immigrant and Community Services***
- ***Brampton Multicultural Community Centre***
- ***Rexdale Community Health Centre***
- ***Brampton Library and India Rainbow Community Services***

One of our success stories comes from our collaboration with Polycultural's Post-Discharge Project:

A 94 year old male patient who speaks only Bengali and Hindi suffered a mild stroke. He lives with his adult daughter but is alone most of the day. The Discharge Planner referred him to the Post-Discharge Project and now he receives weekly reassurance phone calls and friendly visits from a Bengali Friendly Visitor. He expressed his desire to socialize with other seniors and is now set to join an Adult Day Program for South Asian Seniors in his area.

Thank you to all organizations who have collaborated with us - the awards are also yours. Please contact healthequityandinclusion@williamoslerhs.ca if you would like to explore partnerships with us.

Sincerely,

Mary Jane McNally
Chief Patient Experience Officer

Gurwinder Gill
Regional Director, Health Equity & Inclusion

Appendix C: *After the Discharge* Project Support Letters

Support letter, Adult Mental Health, Etobicoke General Hospital

Monday November 21, 2016

To Whom It May Concern,

It is without hesitation that I write this letter of endorsement for the Polycultural Immigrant and Community Services- Post-Discharge Services. As the Social Worker in the Adult Mental Health Unit at William Osler Health System Etobicoke General Hospital, I have come to value this much needed service. The hospital serves a diverse population from many cultural backgrounds who are new Canadians.

In my role as the unit Social worker, linking discharged patients to community resources is a vital component to their successful reintegration. The Polycultural Immigrant and Community Services- Post Discharge Services provide this much needed service. Their immediate response to referrals enables them to meet the patients prior to their discharge and initiate the engagement phase of their work. They are able to meet the ethno-specific needs of my patients by providing services in the mother tongue of many of the patients. Their expertise in immigration and settlement issues provide valuable insights to some of the psycho social stressors many patient's struggle with which impacts on their Mental Health condition. Many of my patient's require hands on assistance with advocating for services, i.e. financial, legal, housing, employment, language and medical services which the case manager is able to assist with. This program truly does strive to meet the patient where they are and assist with fulfilling a need.

The continuation of funding and enhancement of staff resources of this valuable service would be meeting the needs of an ever growing population of underserviced New Canadian with mental health issues that present to Etobicoke General Hospital for help.

Sincerely,

Nancy Mukai-Malonowich M.S.W., R.S.W.,
William Osler Health System -Etobicoke General Hospital
Adult Mental Health Unit.

Support letter, Rehabilitation Unit, Etobicoke General Hospital

William Osler Health System

Wednesday November 30, 2016

To whom it may concern,

Please consider this a letter of support for the Post-Discharge Services for Patients program, provided by the Polycultural Immigrant and Community Services organization.

Working on an inpatient rehabilitation unit at Etobicoke General Hospital, often our patients are discharged from the hospital home with many concerns and anxieties. Having a strong community program such as the Post-Discharge Services allows our patients to transition home, understanding that support may be available to them, and the extra reassurance of regular reassurance checks. Our patients are at ease knowing that a healthcare professional, with awareness of community resources can meet with them at home and assist them in utilizing community programs they might not have otherwise discovered. Friendly visiting provided through the program helps our patients reduce the social isolation they may have been feeling at home prior to admission to hospital, and provides an opportunity to speak to someone about their health, which I believe can prevent future readmissions.

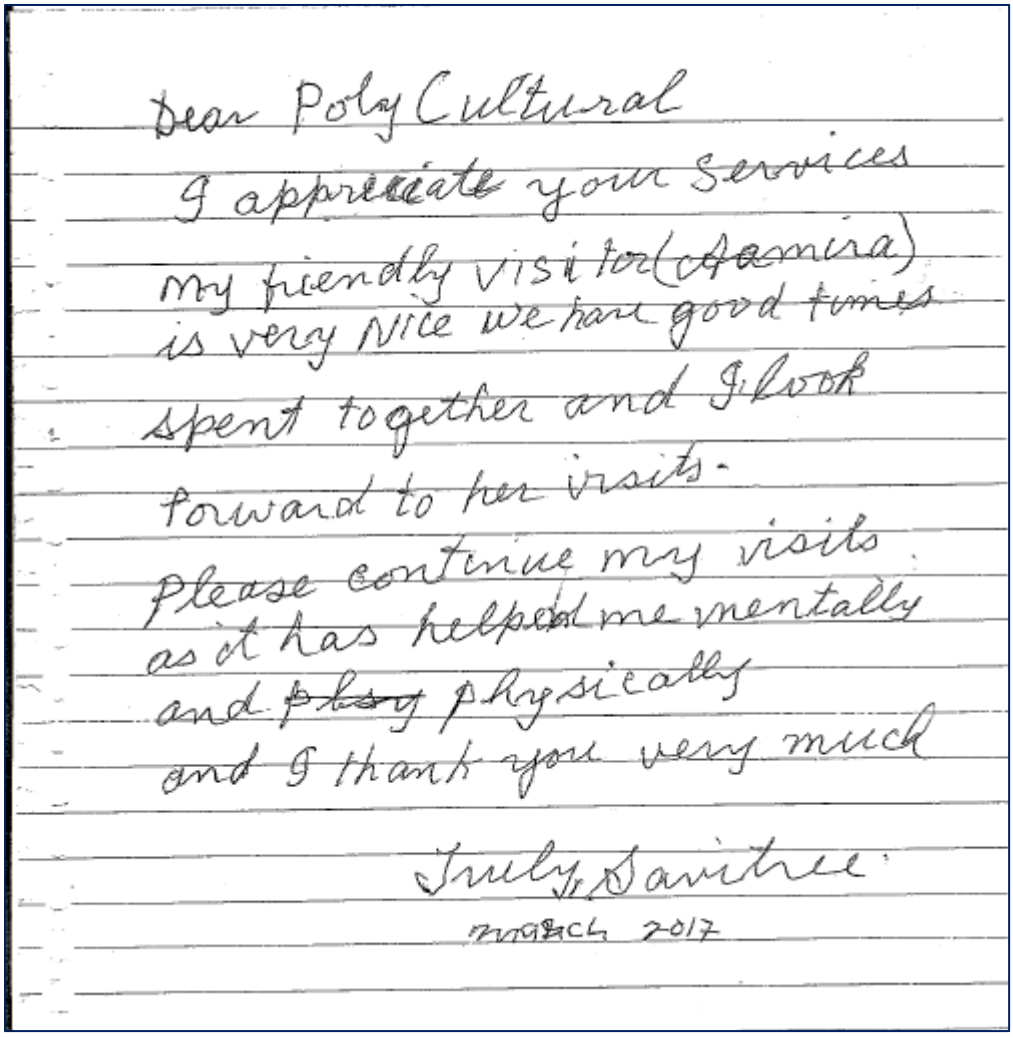
I have referred many patients to this program since it began, and truly feel it does make a positive impact in continuity of care.

Sincerely,

Mike Waechter
Recreation Therapist
Rehabilitation Unit
Etobicoke General Hospital
416-494-2120 ext.32639

Appendix D: *After the Discharge* Service-User Testimonials

Letter 1



Dear Poly Cultural
I appreciate your services
My friendly visitor (Samira)
is very Nice we have good times
spent together and I look
forward to her visits.
Please continue my visits
as it has helped me mentally
and physically
and I thank you very much

Truly, Savithri
March 2017

Letter 2

March 8, 2017

To whom it may concern!

On Dec 13 I had a scheduled appointment with Natasha, social worker from the Outpatient Adult Mental Health Clinic, Etobicoke General Hospital.

The summer months had been extremely difficult for me spending most of my time in the bed low energy, mood swings and in-doors in desire to take a leap in making life better – scary to say the least. I had withdrawn and had become totally isolated.

Natasha suggested three ways my senior days could be improved. She was so approachable, so compassionate, understanding and I felt she truly cared for the golden aged lady giving up. To my surprise a day after my visit, I received a call from Polycultural and questioned this lovely lady what this was all about. 'Friendly visit", that was foreign to me although a full explanation had been given to me by Natasha. It had gone way over my head.

This two hour's friendly visits by Irene Kalakaylo has turned out for me in what I claim as a 'miracle intervention by a higher power". They chose well the person to be with me. She has given me hope in the struggle in changing my attitude towards giving up and in hope that possibly something beautiful could be mine.

How did this happen? Irene, so skilled so it seemed listened well of my cry for help. Practical solutions were what was badly needed in many areas for me to believe in something good. This program referred the best … in no way of 75 years of living, I could have possibly imagined it could be. Let me paraphrase:

1. *With a pen in hand, she simply put down the number and call FIDO customer service to deal with a collector calls that was so disrespectful of me and settled so beautifully. Polycultural, want thank you for choosing the right person to match the need of someone who was so desperate.*
2. *I had forgotten to renew my disability claim form to claim the amount eligible in my case and was stunned to hear $1800 was what I had to pay while I was expecting a $300.00 refund. Irene directed me, guided me and what I believe now will be a successful solution. What a debt of gratitude I owe you Polycultural and especially Irene.*
3. *During the course of our friendly visits, I came down with a bad cold and flu. To this day I still play it over and over in my mind the kind gesture shown to me for a long, long, time. At the door on Valentine's Day Irene showed up with flowers where a full meal and a beautiful delicious Valentin's Cake that's therapy that humanity expressed at its best. I recommend your program now. So others can feel thankful like I did.*
4. *Now the biggie! I need to get out and socialize. That's easier said than done. However, Irena came equipped with the process*

a) *Number and get client number for recreational activities*
b) *Welcome form for policy Application*
c) *Fitness Programs available for seniors*
d) *Ballroom Dance Club number and sharing a personal story of a person she knew who is … same problems*
e) *And much more.*

It is going to be a difficult for me to step out and take the risk but I feel confident with Irene's encouragement and follow up – I will do so!

Thank you, Gracias for this beautiful program – unknown to many which made such a difference in my life. I am eternally grateful!

With much appreciation,

Mrs. M. LeBlanc
(Maggie)

Appendix E: *After the Discharge* Evaluation Tools (surveys)

This survey is for health workers who referred patients to Post-Discharge (formerly known as After the Discharge) services.

Survey Questions
On a scale of 1-5, please tell us a little about your experiences with this service.

1. I am aware of the Post-Discharge services and how it can benefit patients.

Strongly Disagree				Strongly Agree
1	2	3	4	5

2. It was easy to refer patients to the Post-Discharge service.

Strongly Disagree				Strongly Agree	
1	2	3	4	5	N/A

3. Patients are satisfied with the services delivered by the Post Discharge program.

Strongly Disagree				Strongly Agree
1	2	3	4	5

4. This service helps patients manage their needs once they go home from the hospital.

Strongly Disagree				Strongly Agree
1	2	3	4	5

5. In my opinion, this service reduces patient re-admission after their discharge.

Strongly Disagree				Strongly Agree
1	2	3	4	5

6. I recommend this service to patients.

Strongly Disagree				Strongly Agree
1	2	3	4	5

7. I recommend this service to other health professionals.

Strongly Disagree				Strongly Agree
1	2	3	4	5

Do you have other thoughts to share and/or suggestions to improve the service? If yes, please include your comments here.

_____

_____

_____

Thank you ☺

This survey is for patients who benefitted from services after their discharge from the hospital.

Survey Questions
On a scale of 1-5, please tell us a little about your experiences.

1. The staff who contacted me by phone was kind, respectful and helpful.

Strongly Disagree				Strongly Agree
1	2	3	4	5

2. The person who visited me at home was kind, respectful and helpful.

Strongly Disagree				Strongly Agree
1	2	3	4	5

3. The visits were helpful to me.

Strongly Disagree				Strongly Agree
1	2	3	4	5

4. Because of this service, I learned about other services or support in my community.

Strongly Disagree				Strongly Agree
1	2	3	4	5

5. This service connected me with other services that helped me.

Strongly Disagree				Strongly Agree
1	2	3	4	5

6. This service helped me take care of my needs.

Strongly Disagree				Strongly Agree
1	2	3	4	5

7. I would recommend this service to others.

Strongly Disagree				Strongly Agree
1	2	3	4	5

8. Did you require services and visits in a language other than English?
Yes ☐ No ☐

9. Were you re-admitted to hospital for any reason while receiving this service?
Yes ☐ No ☐

Do you have other thoughts to share? If yes, please include your comments here.

Thank you ☺

Evaluator,
Nicole Pietsch

Since 1998, Nicole Pietsch has assisted immigrant and refugee women experiencing domestic violence, marginalized populations of youth, and adult and youth survivors of sexual assault.

Nicole is Evaluator for both the *After the Discharge Project: Economic Opportunities for Immigrant Women* Project (Brampton Multicultural Centre of Peel), and the *Working Together for A Stronger Sexual Violence Response and A Stronger Renfrew County* project (a project of the Status of Women's "Preventing or responding to sexual violence against women and girls through access to community services" priority). In 2013-2014, Nicole was the Gender Specialist in the *Preventing and Reducing the Trafficking of Women and Girls through Community Planning in York Region* Project. Her strategic organizing and priority-setting supported the Women's Support Network of York Region in operationalizing new work, based on community-identified needs, in the community. In 2014, Nicole led a local needs assessment/consultation with youth and women as Researcher /Coordinator in the *Online and Okay Project: Identifying Solutions for Addressing the Problem of Digital Sexual Violence Project,* funded by Women's College Institute's Women's Xchange; and co-led community consultations with diverse youth in collaboration with Planned Parenthood Toronto's strategic planning process.

Nicole's writing has appeared in the Journal of the Association for Research on Mothering, University of Toronto's Women's Health and Urban Life, Canadian Woman Studies, *Reena Virk* (Canadian Scholars Press), namelos Press, and *This is What A Feminist Slut Looks Like* (Demeter Press).

Contact Nicole at nicole.e.pietsch@gmail.com