POLYCULTURAL
IMMIGRANT & COMMUNITY SERVICES

Post-Discharge Project:

Interim Evaluation: Partnerships

for Polycultural Immigrant & Community Services

February 2018

Completed by Nicole Pietsch

Introduction: About the *Post-Discharge* Project

Polycultural Immigrant & 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 *Post-Discharge* Project was developed by Polycultural Immigrant & 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 project has proven to be successful in assisting seniors and marginalised populations immediately after they are discharged from the hospital. Building inclusive and engaged communities together, this initiative will help people who are isolated to have connections in their community.

The *Post-Discharge* Project is in partnership with William Osler Health System, Brampton Civic Hospital and St. Joseph Health Centre.

Overall, this Project aims to:

1. Expand the project to Brampton Civic Hospital, while maintaining activities at Etobicoke General Hospital
2. Expand the project to St. Joseph Health Centre
3. Continue a partnership model between hospitals and the community agency that provides support for seniors and marginalized groups after hospital discharge
4. Provide client-centered support for continuum of care to seniors and marginalized groups
5. Provide culturally and linguistically appropriate services
6. Promote independence and well-being of the program participants through connection to local community resources for physical, mental, emotional and social well-being
7. Support the philosophy/work of Health Links, which has a focus on the Social Determinants of Health for complex patients.

An external evaluation of project outcomes will identify progress, achieved deliverables and further work.

This Report offers an *Interim* evaluation of *project partnerships*. Specifically:

1. Objectives 1-3, above[2]
2. In what ways these objectives were met
3. In what ways Polycultural has fostered a consistent partnership between Polycultural and the project health partners.

[1] Polycultural Immigrant & Community Services. *What We Do.* Online: http://www.polycultural.org/what-we-do
[2] Objectives 4-7 will be assessed in a separate interim service-user engagement/experience evaluation in June 2018.

What is being Evaluated in this Report?

In this Report, an external Evaluator offers an *Interim* evaluation of **partner orientation to and implementation of a partnership model between hospitals and the community agency, Polycultural.**

Overall, we seek to understand the efficacy of Project partnerships – that is, assess:

- The partnership model between hospitals and Polycultural, providing support for seniors and marginalized groups after hospital discharge
- The number of partnerships (hospitals, sites and professionals) represented in the Project thus far
- Formal and informal methods of patient engagement (via health professionals)
- Referral processes for patients
- Continuum of care
- Health professional engagement
- Integration/understanding of Project deliverables and referral processes
- Information flow between hospitals and Polycultural (partnership functioning)

Evaluation data related to this component of the Project was captured and assessed through the following Workplan/Critical Path:

Key Milestone/ Deliverable	Related Tasks	Estimated Task Completion Date
Project Start	Workplan approved	September 15, 2017
Develop Project Client evaluation tool	Meet with Project staff (Project Worker and Project Manager): • Create 1 service-user/client tool • Facilitate orientation to program service-user evaluation tools • Offer best practice/tips for consistent implementation	September 30, 2017
Develop Project evaluation tools: *Process evaluation*	Development of program evaluation tools: • Evaluation guide/outline for health partner professionals • 1 Project participant tool	December 15, 2017
Evaluate Partner Engagement (Interim): *Process evaluation*	Survey to Project partners Phone interviews with healthcare workers and Project staff Assess Project partnerships: • Identify and evaluate partnership model between hospitals and community agency that provides support for seniors and marginalized groups after hospital discharge	December 1, 2017-January 15, 2018

	• Number of partnerships (hospitals, sites and professionals) represented • Formal and informal methods of engagement • Referral processes • Continuum of care Assess partnership processes: • Health professional engagement • Integration/understanding of Project deliverables and referral processes • Information Flow • Partnership functioning and continuity Interim Report/recommendations: Project partnerships	Interim Report: March 2018

In this report, the Evaluator will assess whether or not the Project has been successful thus far in achieving/aiming to achieve the overall all project Objectives 1-3:

1. Expand the project to Brampton Civic Hospital, while maintaining activities at Etobicoke General Hospital
2. Expand the project to St. Joseph Health Centre
3. Continue a partnership model between hospitals and the community agency that provides support for seniors and marginalized groups after hospital discharge

This evaluation will deliver a *formative evaluation* in addressing the above objectives, querying:

- To what degree do healthcare professionals understand the partnership and service delivery model?
- What outreach, engagement and referral processes were used?
- Were project processes clear, engaging, equitable and useful?
- To what degree did healthcare workers serving seniors engage with the project's processes/service delivery model?
- To what degree was the target population (seniors and marginalized patients) engaged to participate via the project's processes and partnerships?

Interim Evaluation, Partnerships: Post-Discharge Project

Is the *Post-Discharge* Project progressing toward meeting its stated Objectives?

Overall, this Project aims to:

1. Expand the project to Brampton Civic Hospital, while maintaining activities at Etobicoke General Hospital
2. Expand the project to St. Joseph Health Centre
3. Continue a partnership model between hospitals and community agency that provides support for seniors and marginalized groups after hospital discharge
4. Provide client-centered support for a continuum of care to seniors and marginalized groups
5. Provide culturally and linguistically appropriate services
6. Promote independence and well-being of program participants through connection to local community resources for physical, mental, emotional and social well-being
7. 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 525 people in the community over the three years period of the overall project.

In this component of evaluation, we seek to specifically understand **the efficacy of project partnerships – that is, assess Objectives 1-3, above,** specifically looking at:

- The partnership model between hospitals and Polycultural, providing support for seniors and marginalized groups after hospital discharge
- The number of partnerships (hospitals, sites and professionals) represented in the Project thus far
- Formal and informal methods of patient engagement (via health professionals)
- Referral processes for patients
- Continuum of care
- Health professional engagement
- Integration/understanding of Project deliverables and referral processes
- Information flow between hospitals and Polycultural (partnership functioning)

Let's begin by looking at Objectives 1 and 2.

Objective 1 and 2: *Expand the project to Brampton Civic Hospital, while maintaining activities at Etobicoke General Hospital and expand the project to St. Joseph Health Centre*

- *To what degree do healthcare professionals understand the partnership and service delivery model?*
- *What outreach, engagement and referral processes were used?*
- *Were project processes clear, engaging, equitable and useful?*

This evaluation found that the project is successfully running at all three partnership hospital sites: Brampton Civic Hospital, Etobicoke General Hospital and St. Joseph Health Centre.

The *Post-Discharge* Project was developed by Polycultural Immigrant & 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. While many health and community services exist in Peel region[3], no dedicated staff or program aimed to link recently discharged immigrant seniors, with the aim of fostering continued community-based care. Oftentimes, socially marginalized individuals, seniors 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 staff must be aware of barriers, and willing to take steps to mitigate them. Others are well-connected to community supports, but may need additional social contact or follow-up support in order to end isolation.

With this in mind, Polycultural Immigrant & Community Services facilitates the *Post-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, Polycultural engaged healthcare staff: first at a management level. A formal agreement (Memorandum of Understanding) between Polycultural and William Osler Health System (that is, both Etobicoke and Brampton hospitals) was in place at the time of the start of project funding. An agreement with St. Joseph's was negotiated in 2017.

On July 25th 2017,Polycultural, together with the Brampton Hospital Health Equity & Inclusion Department organized a program launch. This was attended by approximately 80 frontline staff as well as hospital leaders and local politicians. The launch was featured in the local media (see: The Brampton Guardian/The Mississauga News, https://www.bramptonguardian.com/living-story/7474086-post-discharge-program-will-help-brampton-seniors/).

A formal partnership meeting was held with Willian Osler staff to review the pilot activities (especially the referral process and data collection) from the prior pilot service. Partners talked about strategies for introducing the project to the Brampton site, and together planned the launch event mentioned above. The patient referral form was revised, based on partner (hospital) suggestions at that time.

Project flyers and posters were developed by Polycultural, with hospital staff input, and printed.

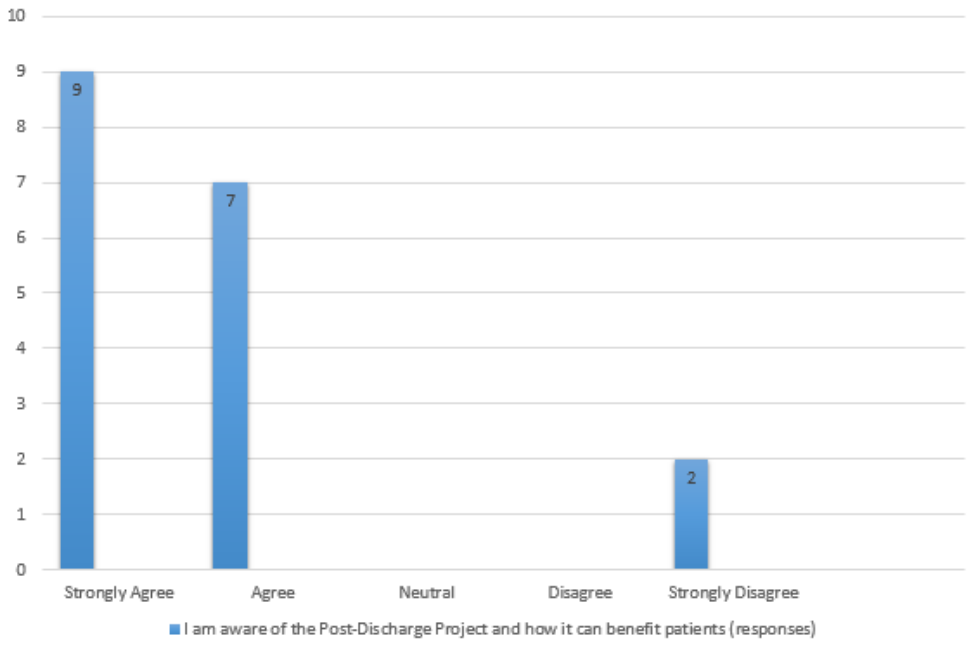
Following the engagement of management level staff at partner hospitals, project staff implemented an in-person outreach campaign at William Osler Health System (both Etobicoke and Brampton) once per week. This outreach campaign sees each Project Facilitator attend Etobicoke and Brampton once per week (one at each location), offering in-person tabling in a busy public space within the hospitals themselves. Project staff find that patients, families, and health professionals alike approach for information. Staff are able to offer print information to those interested, and to engage in discussion, question and answer. Two of the staff working in the *Post-Discharge* Project that were interviewed for this Evaluation – one Coordinator of the project facilitators, and one Project Facilitator – share that it is extremely helpful to have a physical presence in the hospitals in order to foster understanding of the project services and health partner engagement.

[3] See: Region of Peel. *Social Services.* Online: https://www.peelregion.ca/social-services/

The outreach strategy with St. Joseph's differs. The two staff working in the *Post-Discharge* Project that were interviewed for this evaluation identify that St Joseph's Health Centre regularly refers patients to the project overall. Project staff check in informally with these health partners from time to time, in order to assess how the partnership is functioning, and to share information on the outcomes of client referrals.

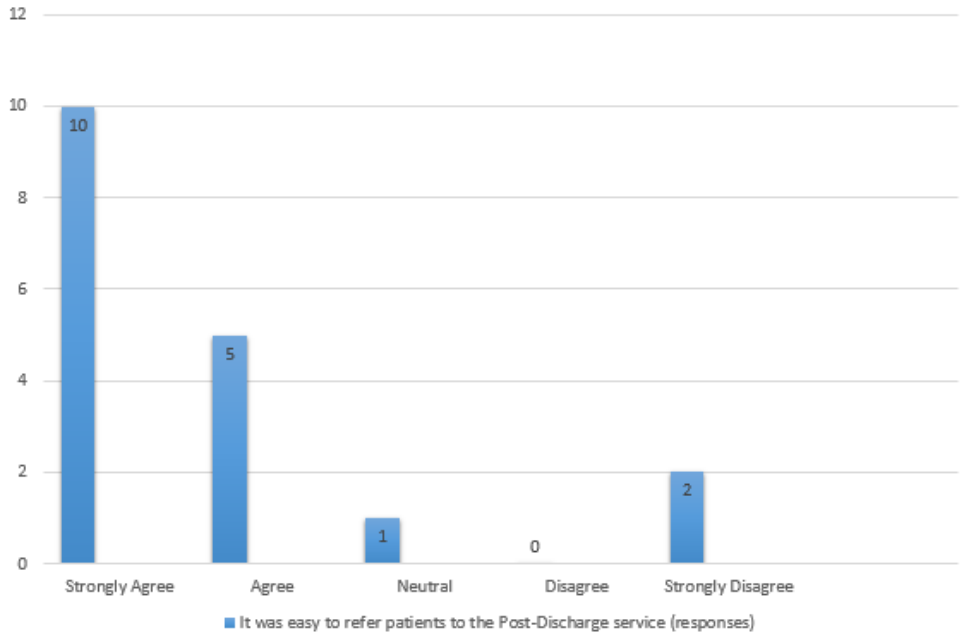
Of 18 health professionals who responded to an evaluation survey, almost all responded positively to the query: *I am aware of the Post-Discharge Project and how it can benefit patients.*

See the visual below:



We can see that, of 18 health professionals who responded to the evaluation survey, almost all (88%) agreed or strongly agreed that they were aware of the service and its benefits.

When queried about the ease of use or access to the Project's services, here is what we learned:



Here, we see that, of 18 health professionals who responded to the evaluation survey, almost all (83%) agreed or strongly agreed that the service was easy to refer patients to. While this category could see some improvement, frontline health partners largely see the project services as easily accessible.

Of health partners that responded to the evaluation survey, 15 of 18 (83%) note that they regularly refer to the service, and 16 of 18 (89%) recommend the service to other health professionals.

Overall, this evaluation finds that ***Objective 1 and 2*** *(Expand the project to Brampton Civic Hospital, while maintaining activities at Etobicoke General Hospital and expand the project to St. Joseph Health Centre)* have been achieved.

Specific strategies and campaigns have been successfully introduced as well, so as to foster partner buy-in and ongoing engagement with the project services.

One limitation to this evaluation is found in the survey respondents. Of 18 health partners that responded to the evaluation survey, 15 were from Brampton Civic Hospital, 2 were from St. Joseph Health Centre, and just one was from Etobicoke General Hospital. One health partner testimonial also resulted from St Joseph's, in addition. While this disparity in participation may point to evaluation participation numbers only, it may also indicate lower health partner engagement at St. Joseph Health Centre and Etobicoke General Hospital in the project overall. For the final evaluation, this Evaluator recommends further efforts to engage participation in the evaluation surveys more evenly across partner hospital sites.

Let's now turn our attention to outcomes connected to Objective 3.

Objective 3: *Continue a partnership model between hospitals and community agency that provides support for seniors and marginalized groups after hospital discharge.*

- *To what degree did healthcare workers serving seniors engage with the project's processes/service delivery model?*
- *To what degree was the target population (seniors and marginalized patients) engaged to participate, via the project's processes and partnerships?*

Overall, this evaluation finds that the partnership between Polycultural and the three hospital sites (Brampton Civic Hospital, St. Joseph Health Centre and Etobicoke General Hospital) has been successful in both introducing and fostering the *Post-Discharge* Project in the community; as well as cultivating healthcare partner engagement with the project services.

As a result of the partnerships with three hospitals, the Project saw referrals from the following health units:

- 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
- Occupational therapist
- Diversity Projects Coordinator[4]

In an evaluation interview, the Coordinator of the *Post-Discharge* Project and project facilitators shared that client targets for the Project thus far have already been exceeded, thanks to robust healthcare partner referrals. For example:

- ✓ The Project has a target of 175 patients referred (total for all three hospitals) per project year

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

- ✓ This year, Polycultural has seen 248 referrals so far from health professionals by mid-March (note that at the time of this report, the one-year period ending March 31, 2018 had not yet ended)
- ✓ Each referred client receives an initial assessment and discussion of needs (some referred persons identify they do not need services/support; but *Post-Discharge* contacts and follow-up on all referred clients)
- ✓ In total this year, the Project has seen 2365 services achieved (services include initial contact, follow-up, referrals to other supports, friendly visitors visits and patient advocacy)

Of health partners that responded to the evaluation survey, 16 of 18 (89%) agreed that the partnership with Polycultural provides additional benefits for patients.

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.

Survey respondents also shared the following comments:

- *"Great program -- I am always recommending it to our frontline healthcare staff."*
- *"We use the fact that patient does not come back to Brampton [Hospital for re-admission] as a factor that they are taken care of in the community."*
- *"Thanks for your ongoing efforts to help Osler patients."*

In addition, Polycultural received the following endorsing letter of support from Etobicoke General Hospital staff who participated in the Project's services, and representing Social Work (Medicine and Palliative Care) of Etobicoke General Hospital:

> *"…I want to reiterate my appreciation and gratitude for the post-discharge program through Polycultural. The most helpful aspects of the program are that there are no limitations on location of [patient] residence (i.e. no catchment area), and that services provided are in keeping with the friendly visiting that so many of our vulnerable seniors are requiring.*
>
> *I find that the program really fills the gaps and 'grey areas' that other programs and agencies miss, and for those reasons I am hopeful that the program can continue to grow."*
>
> *Melissa Devlin, MSW RSW*
> *Social Work (Medicine and Palliative Care),*
> *Etobicoke General Hospital*

This evaluation finds that Polycultural Immigrant & 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.

Overall, this evaluation finds that the project achieved Objectives 1-3.

Post-Discharge: Project Targets

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

	Project Target	Target-related Achievements	Achieved Participation
1.	175 seniors/ marginalized individuals referred per year	• 248 referrals by mid-March (note that at the time of this report, the one-year period ending March 31, 2018 had not yet ended) • In total this year, the Project has seen 2365 services achieved. Services include: - initial contact - follow-up - referrals to other supports - friendly visitors visits - patient advocacy	✓ Achieved

Evaluator Recommendations

Prior to *Post-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. Much feedback from health professionals indicate that *Post-Discharge* offers a unique service where none like it existed before. In addition, the service offers a continuum of care to patients discharged back into the community.

In addition, concerning evaluation survey data on project partnerships: one limitation to this evaluation is found in the survey respondents. Of 18 health partners that responded to the evaluation survey, 15 were from Brampton Civic Hospital, 2 were from St. Joseph Health Centre, and just one was from Etobicoke General Hospital.

While this disparity in participation may point to evaluation participation numbers only, it may also indicate lower health partner engagement at St. Joseph Health Centre and Etobicoke General Hospital in the project overall. For the final evaluation, this Evaluator recommends further efforts to engage participation in the evaluation surveys more evenly across partner hospital sites. We will increase our efforts in this area.

Health-based workers who participated in the evaluation survey made the following practical recommendations concerning partnerships:

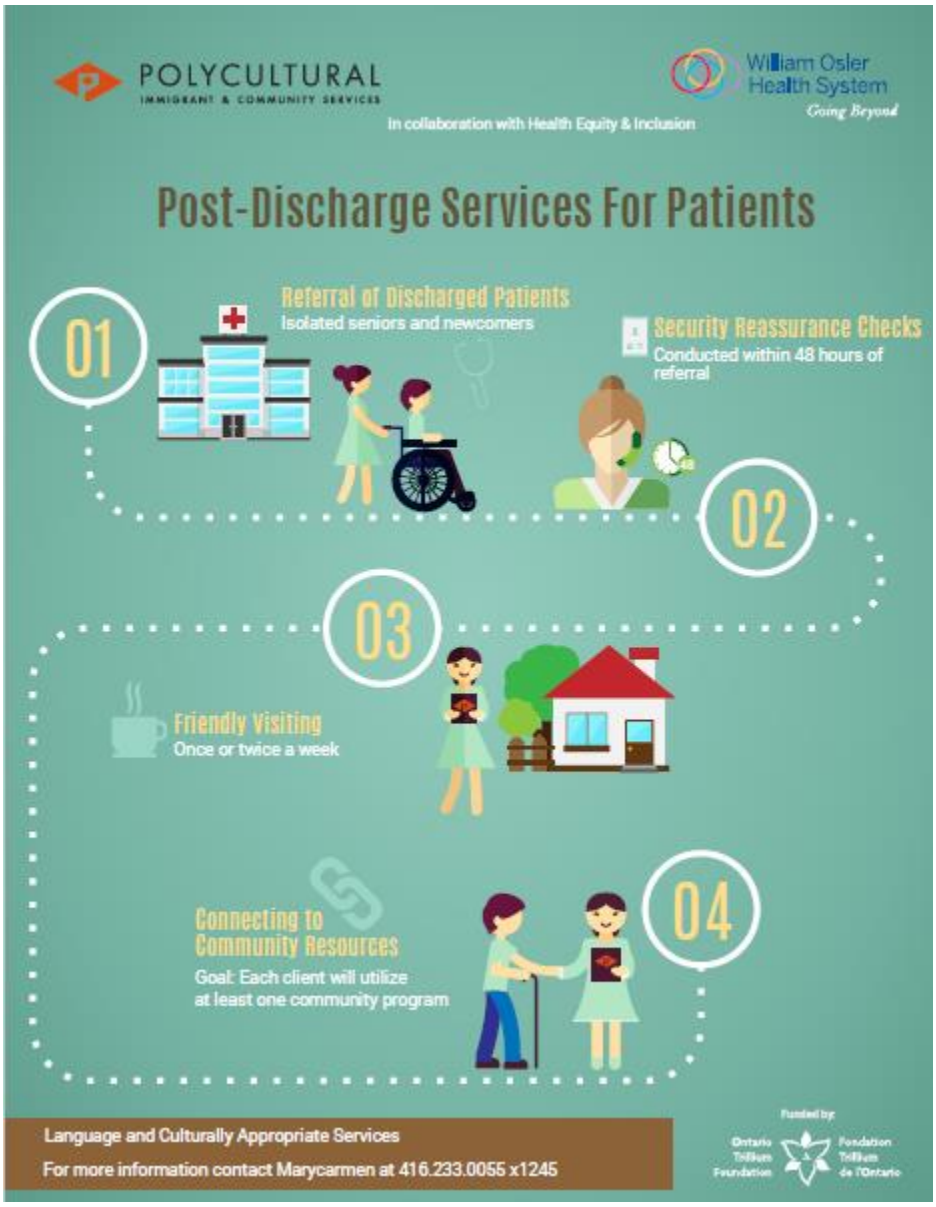
- “Please translate the intake and assessment forms into other common languages” [so that diverse patients can read them independently]
- “I have not received any feedback after patient is discharged to know if the services actually went in, if my referral was appropriate and if it assisted the patient in the way it was intended and that's why I could not answer all questions above regarding after the service was delivered.”
- “We never get feedback re: patient satisfaction.”

In light of the above, this Evaluator recommends that Polycultural’s Project staff consider ways to follow-up with or acknowledge referrals from frontline hospital staff, where possible, more consistently.

For example, you may consider to include an optional box on the patient referral form, querying if the referring health staff would like feedback on the referral. If yes, the referring staff could include their email or extension number on the referral form, and the project staff could follow-up with an acknowledgement contact. Of course, this acknowledgement must be in keeping with Polycultural’s client confidentiality policies.

In the evaluation conversations with the Project Facilitators, we heard that project staff are making this kind of contact with health workers already on an informal basis.

Appendix A: *Post-Discharge* Outreach Poster



Appendix B: *Post-Discharge* Evaluation Tool (survey)

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

- This survey will take you about 5-10 minutes to complete
- You can complete it on hard copy (paper) or online
- This survey is confidential (please do not identify yourself)
- Your feedback helps us to understand how well the Post-Discharge service is serving the community.

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 service 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	N/A

4. I believe 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 to hospital.

Strongly Disagree				Strongly Agree	
1	2	3	4	5	Uncertain

6. I refer patients to this service.

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

8. Our partnership with Polycultural Immigrant & Community Services provides additional benefits for patients.

Strongly Disagree				Strongly Agree
1	2	3	4	5

9. I work at (please choose one or more):
- ☐ Brampton Civic Hospital
- ☐ Etobicoke General Hospital
- ☐ St. Joseph Health Centre

10. My role is best described as (please choose one or more):
- ☐ Working directly with patients
- ☐ An allied health professional (for example, social worker, discharge planner)
- ☐ A department manager or head

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

_____

_____

_____

Thank you for participating!

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 *Post-Discharge Project* (Polycultural Immigrant Services) and the *New Directions Gang Intervention* Project (Brampton Multicultural Centre of Peel). In 2015, she evaluated 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).

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