POLYCULTURAL
IMMIGRANT & COMMUNITY SERVICES

Post-Discharge Project:

Interim Evaluation 2019:
Patient Engagement and Experience, Partnerships and Assessing "Connected People"

For for Polycultural Immigrant & Community Services

January 2019

Completed by Nicole Pietsch

Table of Contents

Introduction: About the *Post-Discharge* Project

Polycultural Immigrant Services & Community Services meets the needs of diverse communities in Metro Toronto and the Regional of Peel[1]. The *Post-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.

With this in mind, Polycultural sought and obtained Ontario Trillium Foundation funding for a targeted *Post-Discharge* program. The *Post-Discharge* Project is in partnership with William Osler Health System (Etobicoke General Hospital and Brampton Civic Hospital) and St. Joseph Health Centre. This project is a Grow Stream beneficiary of the Ontario Trillium Foundation (OTF), building on past pilot success and under the *Connected People*[2] action area.

Building inclusive and engaged communities together, this initiative, led by Polycultural, will help people who are isolated and recently leaving hospital to have increased connections to their community. 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 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.

In context with the overall project, an External Evaluation assesses project outcomes, progress towards the above deliverables, achieved deliverables and remaining work.

This Report offers a robust *Interim* evaluation of the following:

1. Project partnership (health partners) engagement: Achievement of objectives 1-3, above, and in what ways these objectives were met
2. Patient (service user) engagement and experience: Achievement of objectives 4-7, above, and in what ways these objectives were met
3. Assessment of the Project's ability to meet Ontario Trillium Foundation's objectives under the *Connected People* action category (Grow Stream)[3]
4. In what ways Polycultural has met the Project Targets:
   - 175 seniors/ marginalized individuals referred per year to the project's services
   - Implemented a successful partnership model between hospitals and community agency
   - Participants declare that they are well supported by the Post-Discharge Project and their needs are met though participation in community programs as a result of the project.

[1] Polycultural Immigrant & Community Services. *What We Do.* Online: http://www.polycultural.org/what-we-do
[2] Ontario Trillium Foundation (OTF). *Connected People: Building Inclusive and Engaged Communities Together.*. Online: https://otf.ca/what-we-fund/action-areas/connected-people?redirected=1
[3] Ontario Trillium Foundation (OTF). *Grant Results and Metrics by Action Area and Stream*. Online: http://otf.ca/sites/default/files/grantmetrics_allactionareas_en.pdf#page=4. See *Connected People, Grow Stream*: 4.

What is being Evaluated in this Report?

This report assesss three components:

1. Project partnership (health partners) engagement
2. Patient (service user) engagement and experience
3. Assessment of the Project's ability to meet Ontario Trillium Foundation's objectives under the *Connected People* action category (Grow Stream)[4].

Evaluation data related to this component of the project are 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 staffs (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 Assess Project partnerships: • Identify and evaluate partnership model between hospitals and community agency that provides support for seniors and marginalized groups after hospital discharge • Number of partnerships (hospitals, sites and professionals) represented • Formal and informal methods of engagement • Referral processes • Continuum of care	December 1, 2017-January 15, 2018

[4] Ontario Trillium Foundation (OTF). *Grant Results and Metrics by Action Area and Stream*. Online: http://otf.ca/sites/default/files/grantmetrics_allactionareas_en.pdf#page=4. See *Connected People, Grow Stream*: 4.

	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: January 30, 2018
Develop Project evaluation tools	Development of program evaluation tools: • 1 service-user/Project participant tool • Solicit service-user testimonials	March 1, 2018
Evaluate Service-user Engagement/experience (Interim): *Process evaluation*	Survey Project service-users/patients • Obtain collected data • Obtain testimonials • Analyze data resulting from completed program service-user evaluation tools Assess: • Patient-identified Project partnerships (hospitals, sites and professionals) represented • Formal and informal methods of service-user engagement • Referral processes • Continuum of care • Access considerations Assess service-user experience: • Has the project achieved its stated components? • To what degree was the target population (seniors and marginalized patients) engaged to participate in the project? • What outreach, engagement and referral processes were used? • To what degree did seniors/others engage with the project's processes/service delivery model?	May 15, 2018

	• Were project processes clear, engaging, equitable and useful? Interim Report/recommendations: Service-user Engagement/experience	June 1, 2018
Interim Report (2019) *Summative evaluation, Partnerships* *Summative evaluation, Service-user Engagement/experience* *Align Report analysis with Ontario Trillium Foundation (OTF) priority outcomes*	Survey Project partnerships • Obtain collected data Assess Project partnerships Assess partnership, impacts Survey Project service-users/patients • Obtain collected data • Obtain testimonials • Analyze data resulting from completed program service-user evaluation tools Assess service-user engagement Assess service-user experience • Align outcomes, above to Ontario Trillium Foundation (OTF) *Connected People* chart/outcomes • *Connected People* analysis • Identify organizations, resources and programs that the Project refers to (list to be provided by Polycultural) • Align outcomes, above to Ontario Trillium Foundation (OTF) *Social Provisions scale* results (to be provided by Polycultural)	November 2018 January 30, 2019

In this, the Evaluator provides an interim evaluation in response to the Objectives and Project Targets identified on page 2 of this report.

Interim Evaluation, Patient Engagement and Experience, Partnerships and Assessing "Connected People": 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 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.

In addition, Polycultural projected a target of 175 seniors/ marginalized individuals referred per year to the project's services.

Interim Evaluation, Partnerships: Post-Discharge 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?*

The *Post-Discharge* Project was developed by Polycultural 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[5], and in the Greater Toronto Area (GTA), no dedicated staff or program worked to link recently discharged seniors, many of whom are immigrants, with the aim of fostering continued community-based care.

In Polycultural's experiences, socially marginalized individuals, seniors and newcomer families are oftentimes wary or inexperienced in enlisting support from outside (non-family) sources: "Asking for help in a Western context means accessing social and health services from outside sources," one *Post-Discharge* staff noted: " they [service users and their families] are used to asking for help from family. But the family and individual needs are different here"[6]. Families and individuals, in addition, 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 or other components of health and social programs.

In order to bridge these barriers, program staff must be aware of barriers, and willing to take steps to mitigate them. Polycultural staff note that some service users are well-connected to community supports, but may need additional social contact or follow-up support in order to address social isolation or to help them to make meaningful contact with other community support options. With this in mind, Polycultural 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.

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. In order to successfully connect with vulnerable health patients and potential service users, Polycultural engaged healthcare staff at all three hospital sites: first at a management level, and later (as this report will detail), frontline and mid-management staffs.

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.

A formal partnership meeting was held with Willian Osler staff to review the Project's earlier 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. In July 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/).

[5] See: Region of Peel. *Social Services.* Online: https://www.peelregion.ca/social-services/
[6] In a January 2019 interview with Polycultural's frontline *Post-Discharge* Project staff, staff conveyed this information.

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 a Project Facilitator working directly on outreach and engagement with St. Joseph's Health Centre site and Etobicoke General Hospital, and another Project Facilitator works directly with Brampton Civic Hospital.

A staff attends both Brampton Civic Hospital and Etobicoke General Hospital (both William Osler sites) once per week, 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 – two Project Facilitators – 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.

Brampton Civic Hospital has been particularly engaged in supporting outreach activities internally through their Social Inclusion and Equity department. This department helps to share information to patients and staff alike, and supports continued new referrals to the program. Through the Social Inclusion and Equity department, the *Post-Discharge* Project saw mention in the William Osler online newsletter on more than one occasion, and the 2017-2018 *People of Osler* Annual Report Feature (link here). In this feature article, the Brampton Civic Hospital describes "the Post-Discharge Program Supporting Vulnerable Populations [as] a unique partnership between Osler and Polycultural Immigrant and Community Services (Polycultural), an agency that offers a wide range of services and programs for newcomers to Canada"[7]. The article identifies Brampton Civic's Discharge Planner Hope Samuels as "one of the program's biggest champions"[8]. The article goes on to note that since its launch, the Post-Discharge Program has received 250 referrals, "two-thirds from Osler staff, and provided 2,000 individual services – obviously filling a very real need in the community"[9].

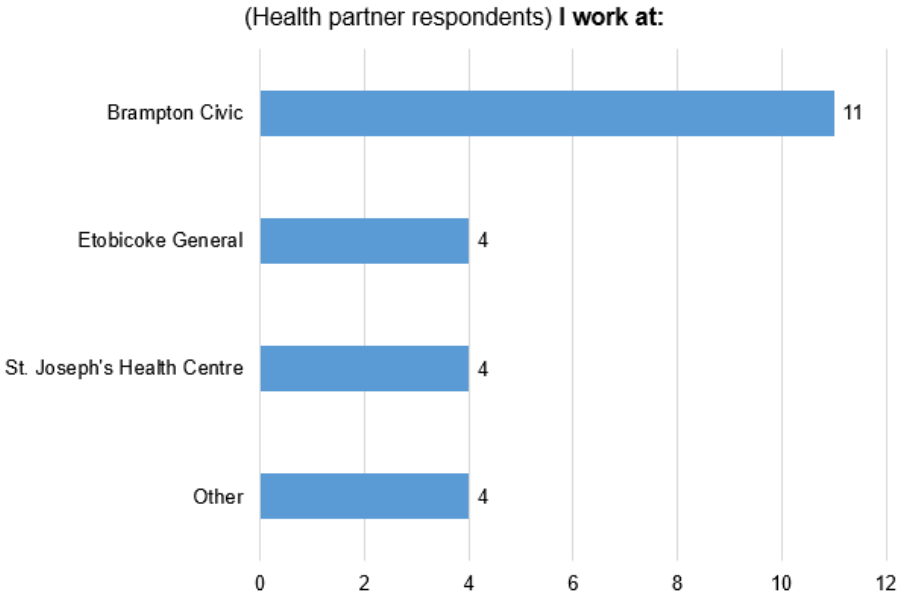
The outreach strategy with St. Joseph's differs. The two staff working in the *Post-Discharge* Project that were interviewed for this evaluation identify that St Joseph's Health Centre regularly refers patients to the project overall.

Project staff check in formally and 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. Project staff offer presentations to staff teams, particularly when a certain department sees staff turnover, restructuring or a change in middle management, as these common human resources transitions can result in reduced awareness of the *Post-Discharge* program offerings and referrals.

Project provide referring health professionals with a referral email, acknowledging the new patient/service-user referral and welcoming follow-up communications. Project staff also send a data summary on active cases (patient/service-user) and referrals once per month. These processes support ongoing communication between Project partners at Polycultural and at health institutions.

[7] William Osler Health System. *New post-discharge program supports vulnerable patients beyond hospital walls.* Online: https://www.oslerreport2017.com/2018/06/08/new-post-discharge-program-supports-vulnerable-patients-beyond-hospital-walls/
[8] Ibid
[9] Ibid

In November-December 2018, we surveyed health partners connected to the *Post-Discharge* Project on their experiences[10] with the Project in 2018. In total, 22 unique health professionals responded to the evaluation survey, representing the following health institutions:



Here, we can see that the majority of respondents are from Brampton Civic (64.71%), with just over 23% respondents from both Etobicoke and St. Joseph Health Centre. In the above, Other includes one professional each from Mount Sinai hospital- Sinai Health System and Circle of care (a community-based health centre) and two from Local Health Integrated Networks (LHINs).

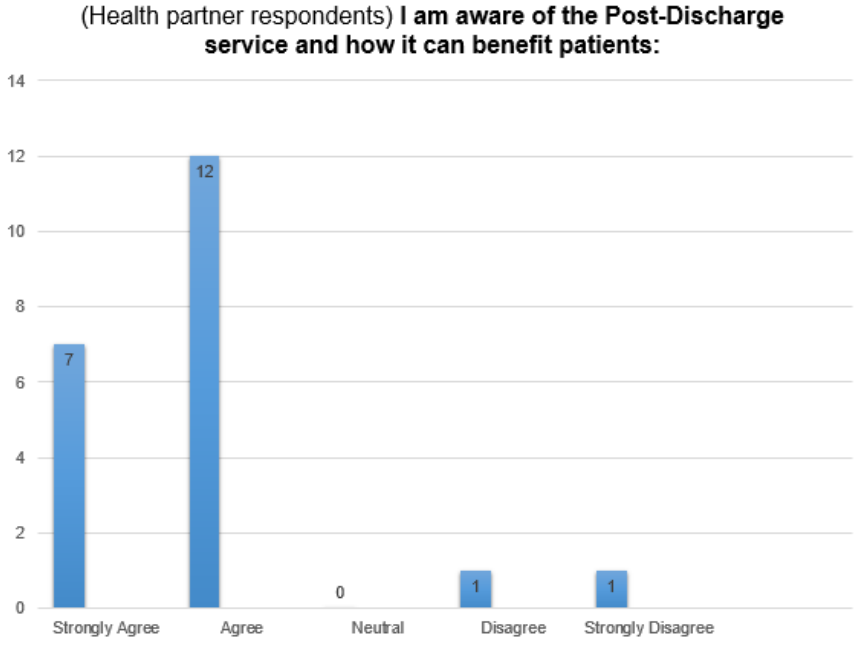
The above notes improved engagement from Etobicoke General Hospital in survey respondents. Last year, of 18 health partners that responded to the evaluation survey, 15 were from Brampton Civic Hospital, 2 were from St. Joseph Health Centre, and just one was from Etobicoke General Hospital.

[10] An earlier health professionals evaluation survey took place in November-December 2017, representing health partners' experiences in the first year of the Project. This survey engaged 18 health professionals engaged in the *Post-Discharge* Project. To review these prior results, see *Post-Discharge* Project: Interim Evaluation: Partnerships for Polycultural Immigrant & Community Services, February 2018.

The 22 respondents from these health institutions represent both frontline health workers and allied health professionals:

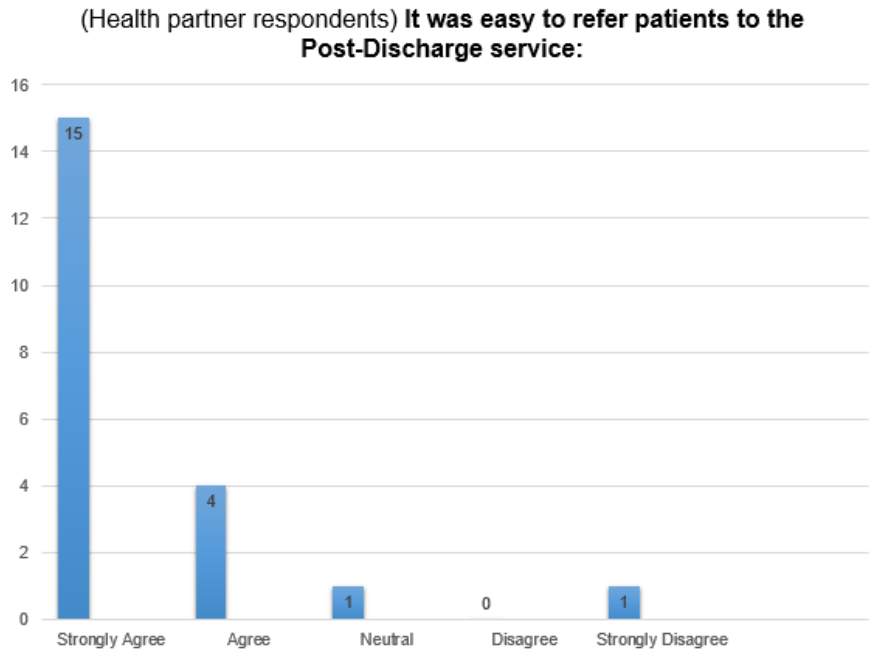
Of the health professionals who responded to the evaluation survey, almost all responded positively to the query: *I am aware of the Post-Discharge Project and how it can benefit patients.*

See the visual below:



We can see that, of 21 health professionals who responded to this question on the evaluation survey, almost all (just over 90%) 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:



Above, we see that, of 21 health professionals who responded to this question on the evaluation survey, almost all (over 90%) agreed or strongly agreed that the service was easy to refer patients to. One response is neutral. This is an improvement from the February 2018 (one year ago) results, in which, two frontline health partners did not find the program to be easily accessible.

Of health partners that responded to the evaluation survey, 20 of 21 (95%) note that they regularly refer to the service, and 19 of 21 (90%) recommend the service to other health professionals. These results align with and slightly exceed positive findings from the February 2018 evaluation report on Project partnerships.

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.

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:

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

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

- Case Manager
- Community partners in community health centres
- Day Surgery Nurse
- Discharge Coordinator
- Discharge Planners
- Diversity Projects Coordinator
- Doctor/hospitalist
- Family doctors
- Nurses
- Occupational therapist
- Physiotherapist
- Recreation Therapist
- Registered Nurses
- Registered Practical Nurses
- Social Inclusion and Equity
- Social workers[11]

[11] In a January 2019 interview with Polycultural's frontline *Post-Discharge* Project staff, staff conveyed this information.

In an evaluation interview, 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
- ✓ Between May 2017 and December 2018, *Post-Discharge* saw 612 service users (total # of Unique Clients who received a direct service through the *Post-Discharge* program)
- ✓ 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 5553 services delivered (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, 19 of 21 (over 90%) agreed that the partnership with Polycultural provides additional benefits for patients. 16 of 21 (over 75%) agreed that the *Post Discharge* service helps patients manage their needs once they go home from the hospital.

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:

- *"I have had a great experience with referrals, and communication with this team. They have been diligent in really supporting client's I have in the community!"*
- *"[Project staff] is wonderful to work with and has been such a great help. Thank you for all you do."*
- *"I like this service because there is no added cost to the patient or their family."*
- *"The service is very easy to refer to"*

In addition, 6 respondents that participated in the evaluation survey for health partners identified that they wished to receive information on what occurred following their referral of a patient to the *Post-Discharge* program. In response to this feedback, Project staff implemented a *Post-Discharge* Program follow up referral mechanism, through which Project staff reach out to referrers via email, acknowledge the referral of a new patient, and identify whether or not the patient enrolled into the program. The email also identifies a Project staff by name and email address, should the referrer require further information on the patient's engagement with the program. For more details on this, see Appendix B: Post-Discharge Referral Email (to health partner making referral).

Other health partner comments include the following:

> *"There are clear non-clinical social indicators that pose significant challenges to the health of marginalized populations. In fact, 50 per cent of what makes us sick is impacted by isolation, income, housing, race, disability, gender," said Gurwinder Gill, Osler's Director, Health Equity and Inclusion. "Partnerships like this one are key to*

> *bridging the gap in health equity and ensuring positive patient outcomes and continuity of care once patients are discharged from Osler"*[12].
>
> *"Polycultural is a great resource in the community in helping seniors with fulfilling the gaps of being alone" (Brampton Civic's Discharge Planner Hope Samuels)*[13].

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.

[12] William Osler Health System. *New post-discharge program supports vulnerable patients beyond hospital walls.* Online: https://www.oslerreport2017.com/2018/06/08/new-post-discharge-program-supports-vulnerable-patients-beyond-hospital-walls/
[13] Ibid

Interim Evaluation, Patient Engagement and Experience: Post-Discharge Project

The second component of this Evaluation seeks to understand the efficacy of patient service-user engagament and experience – that is, assess Objectives 4-7 of the overall Project, below:

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 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.

Let's begin with Objectives 4 and 6, which both address service delivery approach and structure.

Objective 4 and 6:

- *Provide client-centered support for continuum of care to seniors and marginalized groups*
- *Promote independence and well-being of the program participants through connection to local community resources for physical, mental, emotional and social well-being*

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, as well as specific programming to meet the needs of adults, youth and seniors. Services include newcomer orientation, settlement counselling, reception centre for refugees, language training, employment programs for adults and at-risk youth, activities for seniors, community referrals and various psycho-social wellness programs[14]. Well aware of the socioeconomic pressures impacting newcomer and diverse ethnic groups in the region, most services are offered free of charge.

Building on this work in the community, the *Post-Discharge* Project was developed with a specific awareness how older populations of immigrants in the GTA, as well as their family members, experience existing services. Oftentimes, this older immigrant populations lacked prior relationships with community agencies, required language translation in order to learn about or use these services, or were reliant on family members to help them seek out services.

Indeed, Project staff identified the following psycho-social, practical and access needs of *Post-Discharge* service-users, below:

- Access to basic transportation

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

- Ageing and ability to function
- Asking for help in a Western context (that is, accessing extrenal community and health services)
- Barriers to contacting and accessing services
- Basic health and access when there is a language barrier
- Chronic health problems
- Combatting anxieties due to increased technologies and bureaucracy associated with health access today
- Combatting anxiety in traveling to new locations and service providers
- Cultural expectations to "look" and "perform" as well, even when sick or infirm
- Difficulty in accessing/meeting criteria in accessing in-home support (patients require advocate to LHINs to get the services)
- Emotional support
- Fostering and improving life skills
- Greif and bereavement
- Increasing mobility for shut-in patients/service-users
- Life transitions when a caregiver is very elderly and has adult dependents
- Mental health needs
- Nutrition needs for shut-in patients/service-users
- Traveling independently to doctor's appointments and other health-related appointments[15]

These needs exist in addition to *Post-Discharge* service-users' concurrent health-related concerns and needs.

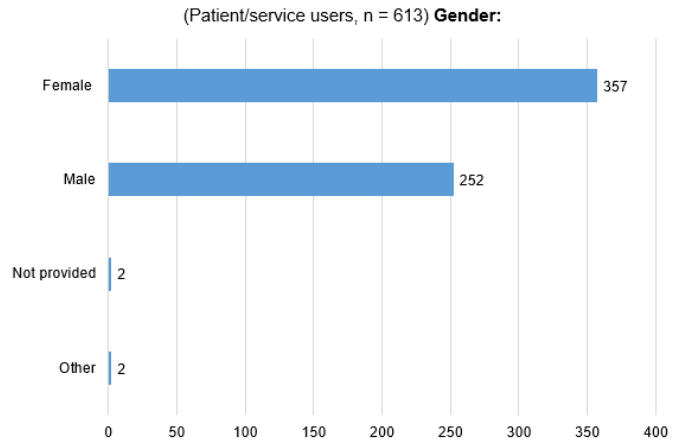
Recognizing all of this, the project aims to approach service-users with a client-centered support model, and offering a continuum of care. *Post-Discharge* project staffs identified the following ways in which client intake/assessment, intervention and referrals incorporate a client-centred framework:

I. Intake and Needs Assessment

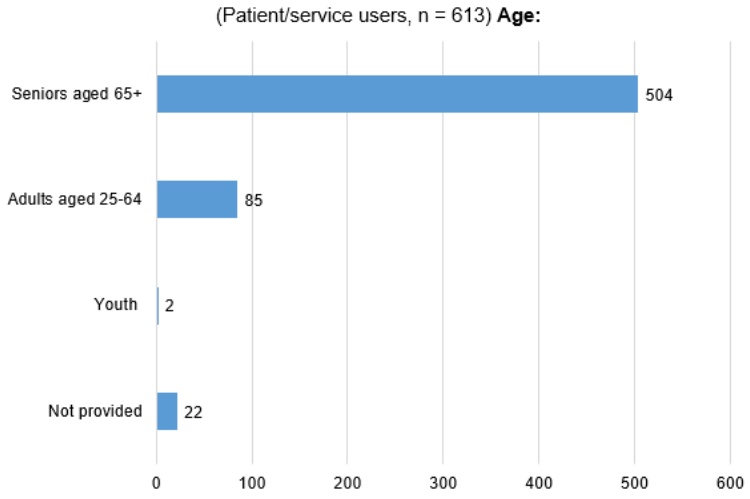
Intake helps Polycultural to understand demographic information – gender, ethnic or country of origin, age and other variables – of the *Post-Discharge* service-user population.

Who make up the *Post-Discharge* service-user population? Based on a demographics summary provided by Polycultural of 613 total *Post-Discharge* service-users (n = 613) between 2017 and December 2018, here is a summary of some known demographics, below:

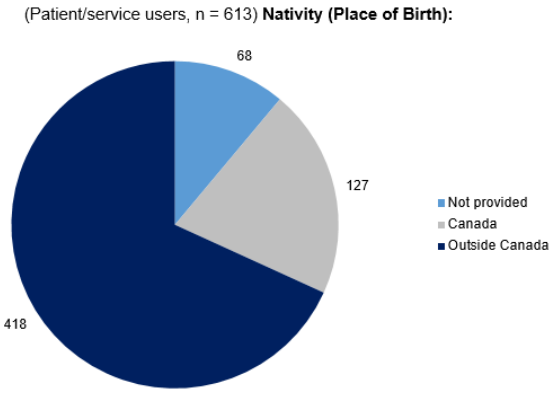
[15] In a January 2019 interview with Polycultural's frontline *Post-Discharge* Project staff, staff conveyed this information.



As we can see above, over half (357 cases, or 58%) of *Post-Discharge* service users are female. Moreover, fully 82% (504 cases) of *Post-Discharge* service users are over the age of 65.



Significantly, the majority of *Post-Discharge* service users are foreign-born (born outside of Canada):



Of those born outside of Canada, the top 10 countries of birth were India (95 case, or 15.5 %), Poland (73 cases or 11.9 %), Italy (35 cases, or 5.7 %), Jamaica (27 cases, or 4.4%); Portugal, Guyana, Pakistan, Germany, Russia and Ukraine saw 25 cases or less each[16]. Certainly, as we will see below, these demographics have an impact on the support needs of service-users.

The client (service-user) intake to *Post-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 in-person or by phone by the project staff after the hospital referral arrives. Needs assessment interviews can also occur in-person with the service-user at the hospital, or soon after their discharge. Where needed, Polycultural Immigrant & Support Services enlists the support of a settlement worker or translator who speaks the language of the service-user.

Oftentimes, families and individuals leaving hospital are unaware of follow-up community supports; or, conversely, are overwhelmed with the amount of information they receive about follow-up care. The project staff ensures that she describes who referred the client (senior service user) to the *Post-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, and housekeeping support.

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. Advocacy needs, where present, are also identified.

For more information on Intake and Assessment, see Appendix C: *Post-Discharge* Services Assessment Form.

II. Intervention

The Project case worker creates a service plan with each client which usually includes a list of organizations that are useful community resources (referrals) based on the needs identified and a Friendly Visitor match based on the client's identified needs, language, age, location, place of residence and other factors. Project staff notes that the program maintains a summary of patient demographics, based on information obtained in intake. This information summary includes client language, country of origin, referring professional, gender, and age. Information helps to match clients to Friendly Visitors.

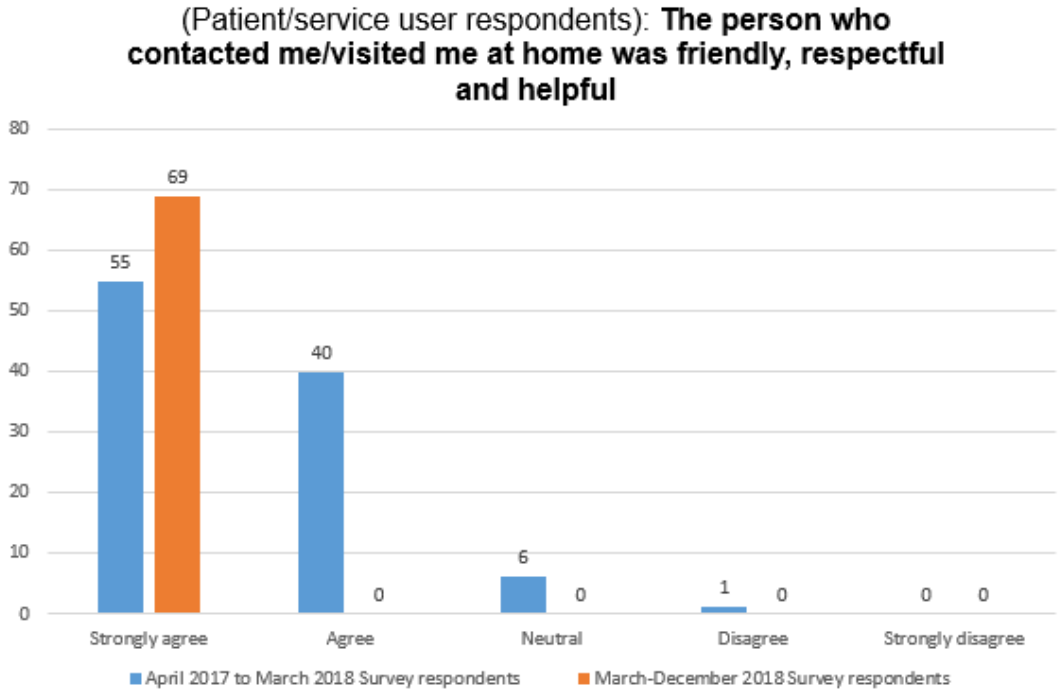
The Friendly Visitor conducts the first visit, then writes a report on the first visit and submits it to the project staff. The report can identify further needs, barriers and goals identified by the client or their family members.

[16] Thanks to Polycultural Community and Immigrant Services for providing this demographic data. See: Polycultural Community and Immigrant Services, *OCMS CLIENT OVERVIEW. Post-Discharge Services*, 2017-2018.

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

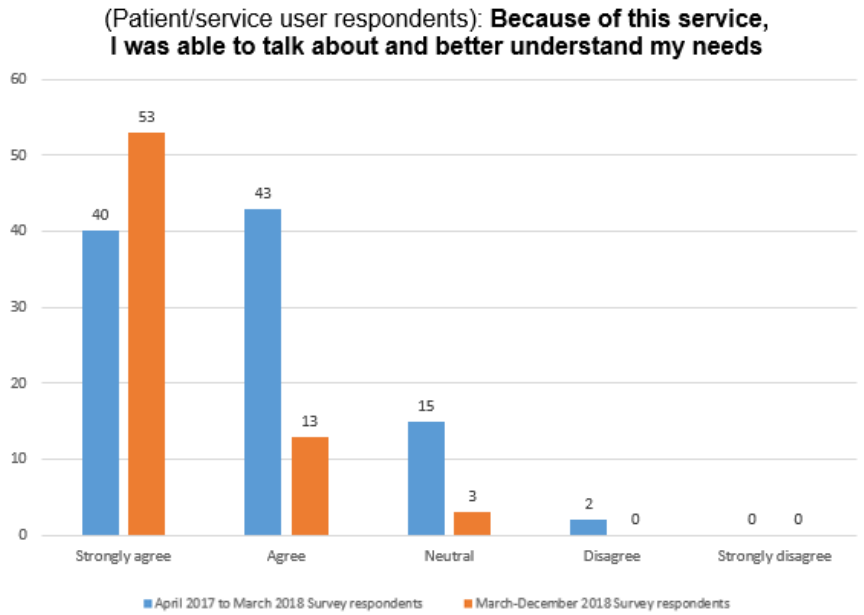
Case workers continues contacting the individual referred for reassurance checks which includes review the progress on referrals, needs addressed, pending or emerging until the case is closed. As per the project framework, the Friendly Visitor conducts visits once per week, for up to three months. However, some clients require less visits; and some have required more (for example, twice per week in the beginning). Services (visits by Friendly Visitors) in the preferred language of the client are provided.

Of all of the project deliverables, the Friendly Visitor component has been appreciated and extremely well-received by program clientele. In a survey of seniors who benefitted from the *Post- Discharge* service, fully 93% of those who completed the survey between April 2017 to March 2018 identified that they *strongly agree* or *agree* that the person who contacted them and visited their home was friendly, respectful and helpful. Marking an improvement in service experience, all of the 69 survey respondents (100%) between March and December 2018 strongly agreed with the statement:



More, the majority of senior clients (88% of those that responded to this survey question; or 149 out of 169 cumulatively from April 2017-December 2018) said that the service helped them to talk about and better understand their needs, following their discharge from the hospital.

See the image below:



This competency (the capacity to understand and talk about one's needs) is consistent over the years of the Project. It can result in more effective emotional support, referrals and connection to community supports, moving forward.

III. Referrals

Referrals to community, social and other supportive services are based on needs identified by the client or their family members. Providing referrals is a twofold strategy: first, referrals often respond to acute or pressing needs or access barriers in the client's life; second, referrals promote independence and well-being of program participants through connection to local community resources for physical, mental, emotional and social well-being. This second strategy aims to address client needs in the long-term, and beyond the duration of the acute (i.e. intake and assessment) period.

The project staff and Friendly Visitors have 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 personnel also maintains expertise on immigrant-serving or ethno-specific organizations that offer targeted services for those facing particular concerns, health or social issues.

Project staff identified the following referrals:

- A1A Care
- Adult day Program
- Albion Neighbourhood Services
- Application of Seniors living and facilitation
- Assisted living
- Braeburn Neighbourhood Place
- Caledon Community Services
- CANES
- Care giver application
- CCAC
- Central Registry

- City of Toronto
- CMHA
- COTA
- CPP Death Benefit
- Crisis Counselling
- Culturally relevant community programming
- Delta Family Resource Centre
- Dental Clinic
- Diet and culture-specific food banks at Muslim Welfare Bank and Red Cross Food Bank
- Dietitian
- Eatonville Care Centre
- EI Compassionate Care Benefits
- Elm Grove Living Centre
- Etobicoke Humane Society
- Etobicoke Services for Seniors
- Fall prevention-Life line
- Family Caregiver Amount Tax Credit
- Friends and Advocates
- Green Meadows Apartments
- Grocery Gateway
- Health Card facilitation-Service Canada
- Heart and Stroke Foundation
- High Park Physiotherapy
- Hospice meeting group
- Housing Connections
- Humber Bay Eye Care
- Indus Community Drop in Program for Seniors
- Internal referrals: Polycultural settlement services and commissioner services
- Knightsbridge Seniors Centre
- Ladies stitching/knitting club
- LAMP
- 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
- Legal Aid/Legal inforrmation
- LHIN
- Lincoln M Alexander Secondary School
- McClintock Manor
- Meals on Wheels
- Mindfulness sessions
- Mississauga Long Term Care Facility
- Multiple Sclerosis Society of Canada
- National Home Doctors Service
- Nurse Next Door
- Nursing home activity programs
- Operation Springboard
- Parkdale Community Food Bank
- Parkdale Golden Age Foundation
- Peel Addictions Assessment and Referral Centre
- Red Cross Mobile Food Bank
- Rexdale Community Services
- Richview Community Care Services Corporation
- Rotary club for Seniors-Bolton
- Senior assisted living
- Senior Centre
- Senior Program
- Senior programming (gentle exercise and social clubs)
- Seniors / Book club
- Seniors Centre
- Seniors programs
- Seniors Travelling resources
- Seniors Wellness Program at local Library
- Serbian Citizens of the World
- Service Canada
- Ship Housing
- Small Claims Court
- St. David's Village
- St. Demetrius Residence
- Storefront Humber Inc
- TeleHealth
- Toronto Intergenerational Partnerships
- Toronto Seniors Healthline
- Toronto Seniors Helpline
- TransHelp
- VHA Rehab Solutions
- Visiting Pet Program
- West Toronto Housing Help Services
- WheelTrans
- White Eagle[17]

[17]Thanks to Polycultural Community and Immigrant Services for providing this demographic data. See: Polycultural Community and Immigrant Services, *OCMS TASKS & REFERRALS. Post-Discharge Services*, 2017-2018.

While *referral* to a service in the community traditionally suggests offering a brochure, phone number or general information about a service, *Post-Discharge* staff and volunteers augment this practice, often 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, discussing the referred service with the senior, or completing an intake to the referred service during a Friendly Visitor visit.

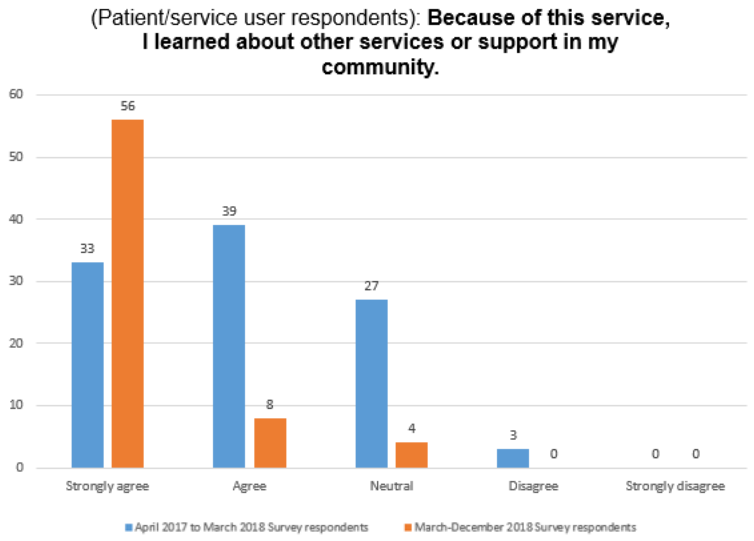
Service user testimonials collected in 2017 and 2018 often describe Friendly Visitors who helped the senior to complete forms needed to access income supports, health-related services (such as physiotherapy or physical rehabilitation), or direct support in accessing transit (i.e. planning a route on a transit map).

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 also occur where needed.

This Evaluation finds that this nuanced 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 *Post- Discharge* service between April 2017 and March 2018, over 70% of those who completed the survey (72 of 102 respondents to the question) identified that they *strongly agree* or *agree* that because of this service, they learned about other services or support in the community. In the most recent year of the Project (March-December 2018), the *Post- Discharge* service saw a marked increase: 94% of those who completed the survey (64 of 68 respondents to the question) identified that they *strongly agree* or *agree* that because of this service, they learned about other services or support in the community.

This marks an improvement in the service-user experience of *Post- Discharge*:



Moreover, in the most recent year of the Project (March-December 2018), 93% (63 of 68 respondents to the question) also *agreed* or *strongly agreed* that the *Post-Discharge* service connected them with other community services that helped them.

Overall, these positive results identify a service model that offers a client-centered support for continuum of care. Additionally, evaluation surveys with *Post-Discharge* clients shows that the service-user experience has seen improvement in the Project's most recent year. This Evaluation finds that the service model promotes independence and well-being of the program participants, through successful connection of clients to local community resources.

Objective 5: *Provide culturally and linguistically appropriate services*

A client-centred approach also includes providing culturally and linguistically appropriate services within the context of the project.

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[18]. 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[19]. The Greater Toronto Area (GTA) sees comparably diverse demographics: In 2016, 47 per cent of the GTA population was immigrants, much higher than the national rate of 21.9 per cent. In 2016, over half of Torontonians (51.5 per cent) identified as belonging to a visible minority group[20].

Certainly, social location – such as age, gender, status in Canada and race – can have an impact on one's experiences of health and social services. Regional examples of the connections between health and social location include the following realities:

- There are more than 90 languages spoken in Peel region[21]. 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
- More than 20 languages comprise the top languages spoken in each Toronto neighbourhood: Mandarin, Spanish, Italian and Portuguese are widespread, well-established languages across Toronto. Tamil and Punjabi, once less spoken, are now and dozens of other spoken languages are predominant and evergrowing in smaller local enclaves[22]
- 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[23]

[18] 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
[19] Region of Peel. *Quick Stats: Visible Minorities.* Online: https://www.peelregion.ca/health/statusdata/pdf/ethnicity-c.pdf
[20] Toronto Foundation. *Vital Signs Report 2017/18.* Online: https://torontofoundation.ca/wp-content/uploads/2018/01/TF-VS-web-FINAL-4MB.pdf: 10.
[21] Peel Regional Diversity Roundtable (RDR). *Why Peel?* Online: http://www.dicharter.rdrpeel.org/about-us-our-story/
[22] Ibid.
[23] See: Canadian Ethnocultural Council. 2013. *A Community Guide on Diabetes in Immigrant Ethnic Populations: Sample Programs for Early Detection and Management,* p. 3-4

- Nearly 40% of Peel seniors live in poverty[24]. The Toronto *Vital Signs Report 2017-2018* nots that while Toronto is a wealthy city, the level of wealth inequality can be striking: in some areas, barely one person in 30 lives below Statistics Canada's poverty line while in others, two out of every three residents live in poverty[25].
- Significantly, Toronto has a significantly higher proportion of older adults (aged 55–64) receiving Ontario Disability Support (ODSP) than other metropolitan areas in Canada[26].

Polycultural Immigrant & Community Services is well aware that these contexts can create service barriers to community members. It is worth noting, in addition, that based on a demographics summary of 613 *Post-Discharge* service-users (n = 613) between 2017 and December 2018, the program saw the following top languages spoken: Polish (77 cases, or 11.4 %), Punjabi (66 case, or 9.8 %), Italian (31 cases, or 4.6 %); and Portuguese, Hindi, Russian, Spanish, Urdu, Ukrainian and German (each comprising 4% or less of the total service-user group)[27].

The *Post-Discharge* service model aims to mitigate these barriers through intentional culturally and linguistically appropriate services. Significantly, our evaluation survey of service-users found that *over half* (46 of 100 respondents to the question in the earlier evaluation period; and 42 out of 72 between March and December 2018 – a cumulative total of 51%) *Post-Discharge* service recipients indicated that they required service in a language other than English. Languages identified in this Evaluation term[28] by service recipients[29] and provided by Friendly Visitors and Polycultural settlement staff include

- Punjabi
- Punjabi and Hindi
- Polish
- Urdu
- Portuguese
- Pashtu
- Russian
- Spanish
- Italian

Of these, Polish, Urdu and Punjabi languages were requested the most[30]. Of the above (42 service-users) in this Evaluation term, all indicated that they received *Post-Discharge* services in their preferred language. For more information on culturally appropriate services within the context of the project, please see Referrals on page 20-21 of this report.

In this, Objective 5 is successfully met.

[24] Ibid
[25] Toronto Foundation. *Vital Signs Report 2017/18.* Online: https://torontofoundation.ca/wp-content/uploads/2018/01/TF-VS-web-FINAL-4MB.pdf: 11.
[26] Toronto Foundation. *Vital Signs Report 2017/18.* Online: https://torontofoundation.ca/wp-content/uploads/2018/01/TF-VS-web-FINAL-4MB.pdf: 46.
[27] Thanks to Polycultural Community and Immigrant Services for providing this demographic data. See: Polycultural Community and Immigrant Services, *OCMS CLIENT OVERVIEW. Post-Discharge Services*, 2017-2018.

[28] This Evaluation term is the second year of the funded *Post-Discharge Project*: that is, March–December 2018. Where evaluation scores are cumulative (that is, from April 2017 until December 2018), this is clearly identified.
[29] Languages identified in client (service-user) evaluations surveys completed between March–December 2018.
[30] While all survey respondents indicated *whether or not* they required services in a language other than English, not all identified *their preferred language*. For this reason, this Evaluation was unable to assess the number of service recipients accessing services by language.

Objective 7:

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

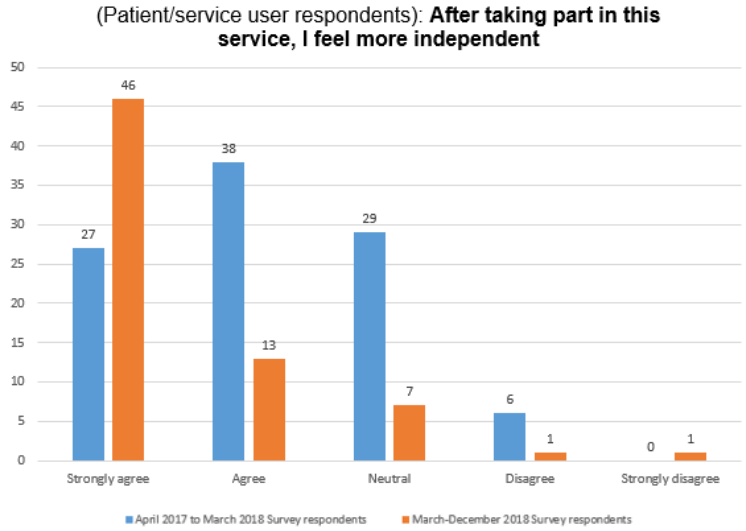
The *Post-Discharge* Project maintains the philosophy/work of Health Links, which has a focus on the Social Determinants of Health for complex patients.

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"[31].

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.

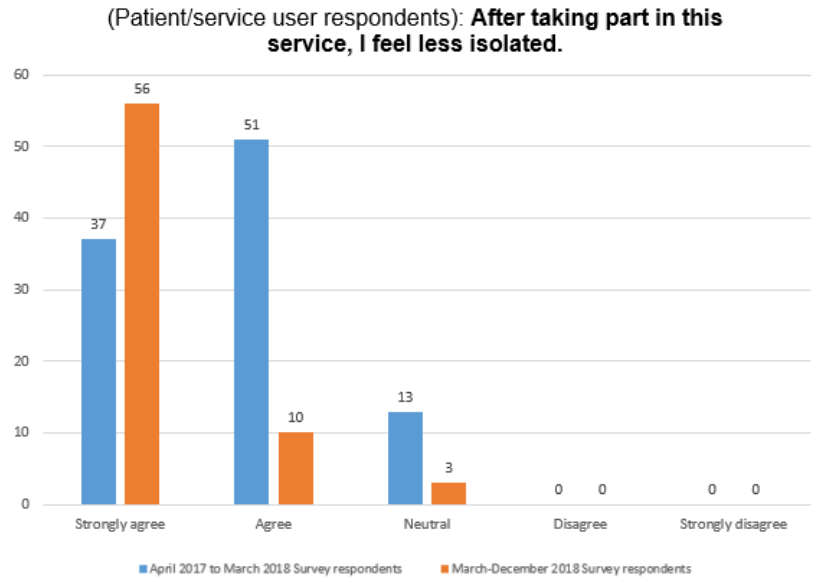
As identified earlier in this report, the majority of senior clients (88% of those that responded to this survey question) said that the service helped them to talk about and better understand their needs, following their discharge from the hospital.

In addition, most respondents (87% *agreed* or *strongly agreed*) shared that the service had a positive impact on their independence. This is significant increase when compared to last year's *Post-Discharge* survey responses, which indicated that only 63% *agreed* or *strongly agreed*):



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

More, we can see that fully 66 of this year's (March-December 2018) total 69 respondents identified that the service helped them to feel less isolated. No respondents disagreed with the statement concerning isolation:



In the context of the project deliverables, service-user needs represent a range of necessities: physical health needs, social needs and mental health needs. More, service-users also identify practical needs such as housing, help in obtaining income support or settlement supports – all which the project has recognized as relevant. In response, program staff assess for these issues in their intake and assessment, and create client plans that aim to address them.

Testimonials obtained in 2018 from clients largely speak to project staffs' ability to access services or support in their community, or actively reduce their isolation. The project received 20 unique testimonials from clients and their family members between March and December 2018; and 31 between April 2017 and March 2018.

Some testimonial narratives in the most recent period (between March and December 2018) are captured here:

- *"By myself, it is very hard to live. After the stroke I could not function and communicate well. Thanks to the [Post-Discharge] services I have assistance and an interpreter for all my medical appointments, help from Humber Home Support and cleaning [help] twice per month. I also have the WheelTransit [accessible transit bus] and help in booking [travel] trips."* Service user testimonial, 2018

- *"I am here in Canada by myself. My family and relatives are abroad…I am retired and feel lonely. That's why I am thankful for the [Post-Discharge] services: interpreting and assisting when I need the doctor's office, also conversations during friendly visits. I feel more confident that I have someone responsible, who I share my needs with"* Service user testimonial, 2018

- *"This program helped me in a time of my life when I really needed someone to visit me in hospital, in my home after surgery, during my appointments with oncologist, and later with eye doctor and cataract surgery. My friendly visitor is a very communicative person, outgoing and friendly…I feel very supported."* Service user testimonial, 2018

- *"[Email addressed to Friendly Visitor] Thank you for such a wonderful and much needed visit. You helped to save me from a weekend of misery. You have quite a gift the way you interact with people. I look forward as always to seeing you next week."* Service user testimonial, July 2018

- *"When she [Friendly Visitor] comes, I discuss my problems and then we talk to find out how to solve the problem, we talk about groceries, healthy eating and physical exercise."* Service user testimonial, 2018

- *"I feel less isolated with her [Friendly Visitor]. I am really thankful for her and the service."* Service user testimonial, 2018

- *"The visits make a difference in my everyday life. I am alone and most f the day I spend in front of the TV. I am very happy when somebody visits me and I can talk with them."* Service user testimonial, 2018

- *"The visits of the Friendly Visitor were helpful for me to walk together to the community centre…and to walk with my dog when I was very weak, after being in hospital."* Service user testimonial, March 2018

These testimonials identify the ways in which *Post-Discharge* services align with the Health Links model, which maintains a focus on meeting the Social Determinants of Health for complex patients. The Evaluation particularly notes the ways in which services reduced isolation, increased service-user motivation and social support, and connected seniors to other needed services. These concepts – *reducing isolation, increasing service-user motivation and social support,* and *connecting service-users to others* – will also be explored under the next section of this Evaluation: *Connected People,* on page 29.

Last, as a means of meeting the mandate of Health Links, the project maintains formal partnerships with three hospital sites and numerous healthcare professionals. Aligning with the notion of collaborative partnerships, within this Evaluation term, the project saw referrals from the following health units:

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

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

- Case Manager
- Community partners in community health centres
- Day Surgery Nurse
- Discharge Coordinator
- Discharge Planners
- Diversity Projects Coordinator
- Doctor/hospitalist
- Family doctors
- Nurses
- Occupational therapist
- Physiotherapist
- Recreation Therapist
- Registered Nurses
- Registered Practical Nurses
- Social Inclusion and Equity
- Social workers[32]

Overall, this evaluation finds that the Project achieved Objectives 4-7.

[32] In a January 2019 interview with Polycultural's frontline *Post-Discharge* Project staff, staff conveyed this information.

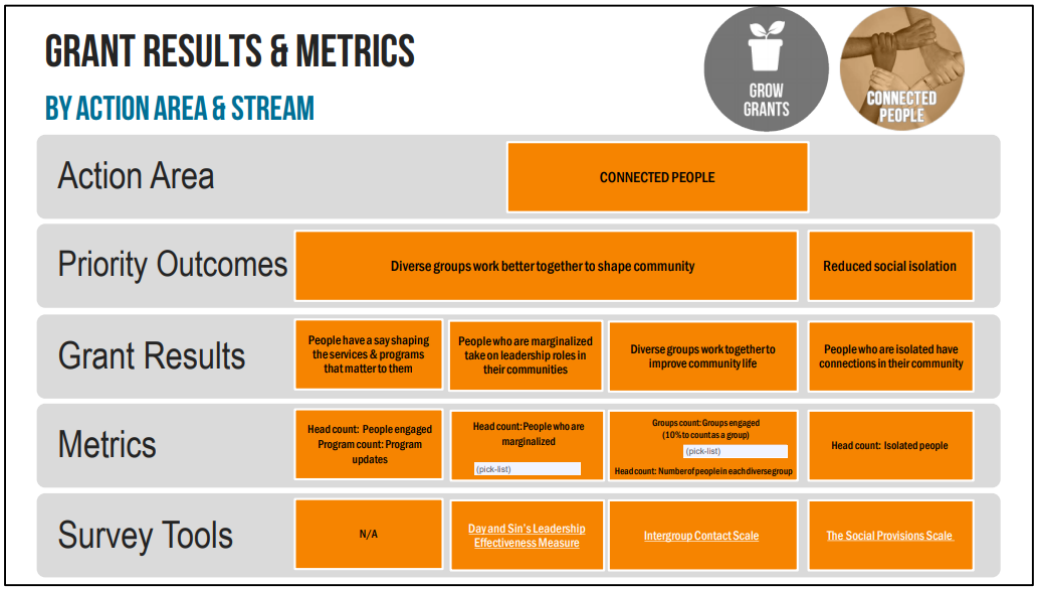
Interim Evaluation, Assessing "Connected People": Post-Discharge Project

The final component of this Evaluation seeks to understand the Project's ability to meet Ontario Trillium Foundation's objectives under the *Connected People* action category (Grow Stream)[33]. *

Ontario Trillium Foundation (OTF)'s *Connected People* action category aims to build "inclusive and engaged communities together" [34]. People's ability to connect with each other and participate in society, OTF notes, is central to community health and vibrancy:

> "A sense of belonging -- when we feel comfortable and welcome in a place -- translates into very tangible actions and behaviours in people and communities. Creating, establishing and maintaining essential connections is strongly associated with improved physical and mental health, both of which are key to building and maintaining vital communities"[35].

Under the Grow Stream at OTF, connection to others is assessed via the following metrics:



Ontario Trillium Foundation (OTF). *Grant Results and Metrics by Action Area and Stream: Connected People, Grow Stream*.

As a Project funded under the *Connected People* action category (Grow Stream)[36], the *Post-Discharge* Project aims to see improvements in in its targeted population's ability to and an increased ability to participate in the community, make connections with others, and see a

[33] Ontario Trillium Foundation (OTF). *Grant Results and Metrics by Action Area and Stream*. Online: http://otf.ca/sites/default/files/grantmetrics_allactionareas_en.pdf#page=4. See *Connected People, Grow Stream*: 4.
[34] Ontario Trillium Foundation (OTF). *Connected People*. Online: https://otf.ca/what-we-fund/action-areas/connected-people
[35] Ontario Trillium Foundation (OTF). *Why do we invest in Connected People?* Online: https://otf.ca/sites/default/files/connected_people_story.pdf
[36] Ontario Trillium Foundation (OTF). *Grant Results and Metrics by Action Area and Stream*. Online: http://otf.ca/sites/default/files/grantmetrics_allactionareas_en.pdf#page=4. See *Connected People, Grow Stream*: 4.

decrease in isolation or loneliness as a result. With this in mind, the *Post-Discharge* Project oriented its service-user outcomes around these competencies, and worked to foster them through program offerings such as assessment of needs, client advocacy, effective referrals, friendly visits, and connection to community programming.

This evaluation notes that the preceding section (*Objective 7: Support the philosophy/work of Health Links, which has a focus on the Social Determinants of Health for complex patients)* also describes competencies similar to *Connected People,* such as increased connection with others and a resulting decrease in social isolation or loneliness. *Post-Discharge* client testimonials, above, also speak to these competencies.

In this component of the Evaluation, this report will assess the project's efficacy via analysis of results on the following *Connected People* metrics:

- ***Reduced social isolation/People who are isolated have connections in their community***
- ***Improved Social Provision results pertaining to reduced isolation and connection to others in the post-program phase of service-user survey***

Existing research identifies the critical importance of social inclusion – and, on the other hand, the negative impacts of *exclusion and loneliness* – upon socially marginalized populations[37]: loneliness is a "painful, unwelcomed experience that has consequences detrimental to one's emotional, physical, and spiritual well-being"[38]. Loneliness has been linked to negative outcomes, such as depression, hostility, alcoholism, poor self-concept, psychosomatic illnesses [and] an increased vulnerability to health problems[39]. Personal circumstances, such as few personal relationships, limitations in forging new relationships, limited physical or social mobility and "experiences of exclusion from mainstream society" can significantly impact experiences of loneliness on particular groups of people[40].

Conversely, having connections and "being socially integrated—meaning partaking in a broad and diverse range of social relationships in one's community—has been associated with social well-being and physical health outcomes (Cohen, Doyle, Skoner, Rabin, & Gwaltney, 1997; Machielse, 2006)"[41].

With this in mind, Polycultural's *Post-Discharge* programming intentionally works to address the OTF priority outcome of reducing social isolation. Where this outcome is achieved, people who are isolated will have connections in their community, and isolated people (in this context, *Post-Discharge* service-users) see an increase on the OTF Social Provisions Scale.

[37] See Meyer, I. In *Psychological Bulletin* Copyright 2003 by the American Psychological Association, Inc. 2003, Vol. 129, No. 5, 674–697; and Cameron, A. Geographies of welfare and exclusion: Social inclusion and exception. In *Progress in Human Geography 30, 3* (2006) pp. 396-404.
[38] Rokach, Amy. The Causes of Loneliness in Homeless Youth. In *The Journal of Psychology,* 2005, 139(5), 470.
[39] Ibid.
[40] Bower, M. Australian homeless persons' experiences of social connectedness, isolation and loneliness. In Health and Social Care in the Community. 2018; 26: 247.
[41] Bower, M. Australian homeless persons' experiences of social connectedness, isolation and loneliness. In Health and Social Care in the Community. 2018; 26: 241

The Polycultural's *Post-Discharge* Project implemented testing of service-user responses to the Social Provisions Scale survey. The survey was deployed as a two-step pre-program and post-program survey: that is, *Post-Discharge* service-users completed the survey questions as they began accessing *Post-Discharge* services, and then completed the survey a second time following their completion of *Post-Discharge* services. Results (pre-program and post-program survey scores) were compiled and summarized by Forum Research for OTF. Forum Research provided Polycultural and the Evaluator with the raw pre-program and post-program survey scores on a data-set file.

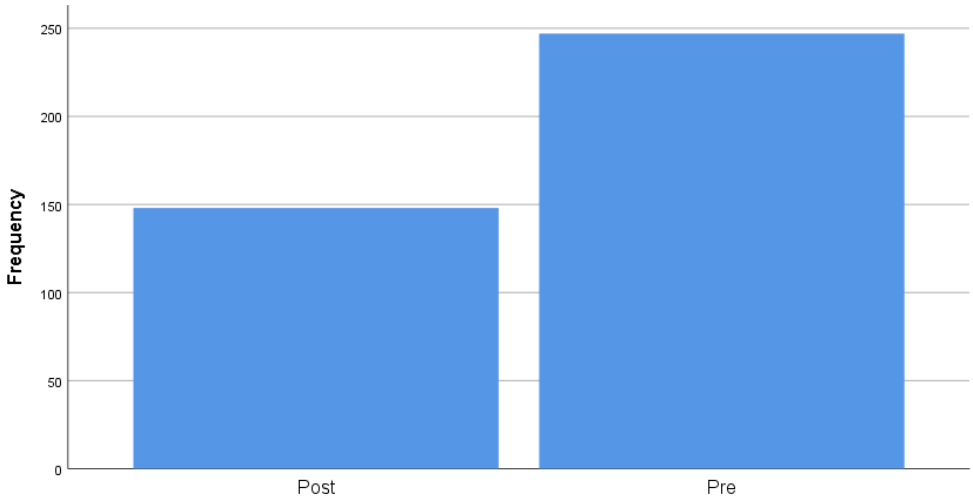
The Evaluator coded pre-program survey scores (pre-program survey = 1) and post-program survey scores (post-program survey scores = 2). Using IBM SPSS version 25 (a statistics software program), the Evaluator compared survey respondents' responses *before* and *after* their engagement with *Post-Discharge* services.

To begin, how many people that benefitted from the *Post-Discharge Project* participated in the pre- and post- (Social Provisions Scale) survey? Let's take a look at the results:

Post-Discharge service-users that participated in the pre- and post- (Social Provisions Scale) survey:

	Frequency	Percent	Valid Percent	Cumulative Percent
Post	148	37.5	37.5	37.5
Pre	247	62.5	62.5	100.0
Total	395	100.0	100.0	

Visual (bar chart) representation:



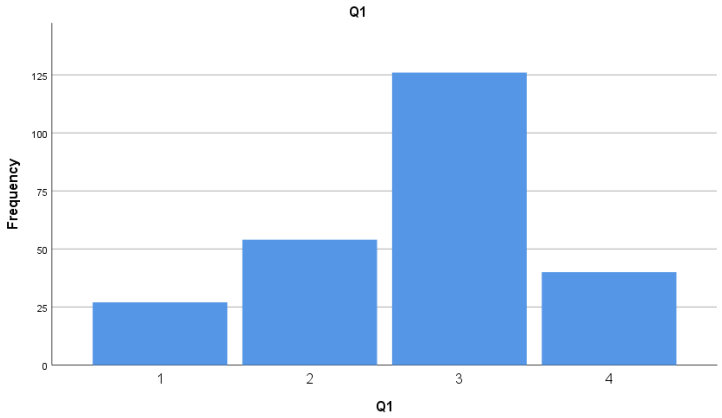
Here, we can see that 395 *Post-Discharge Project* service-users participated in the pre- and post- (Social Provisions Scale) survey. Of this total, 148 completed the pre-program survey and 247 completed the post-program survey.

In what ways did *Post-Discharge* program beneficiaries experience social isolation? Did their participation in *Post-Discharge* program services shift these experiences? This evaluation looked at Questions 1, 11, 17 and 23 of the Social Provisions Scale survey, each of which addresses social isolation, loneliness and connections to others. From here, we assessed the pre-program survey responses of each question against the post-program survey responses.

Let's take a look at the results:

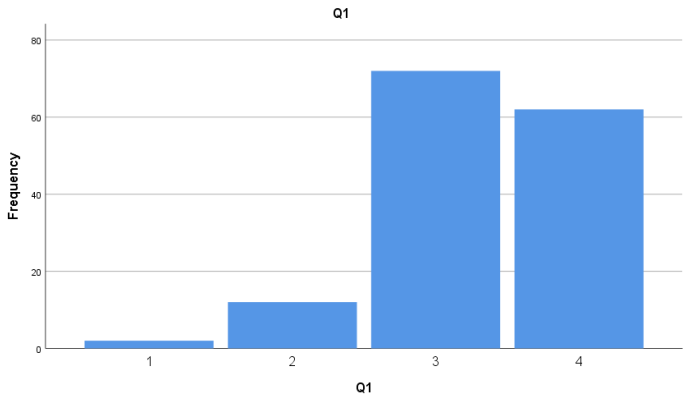
Q1: *There are people I can depend on to help me if I really need it.*

Pre- survey responses



1 = Strongly Disagree
2 = Disagree
3 = Agree
4 = Strongly Agree

Post- survey responses



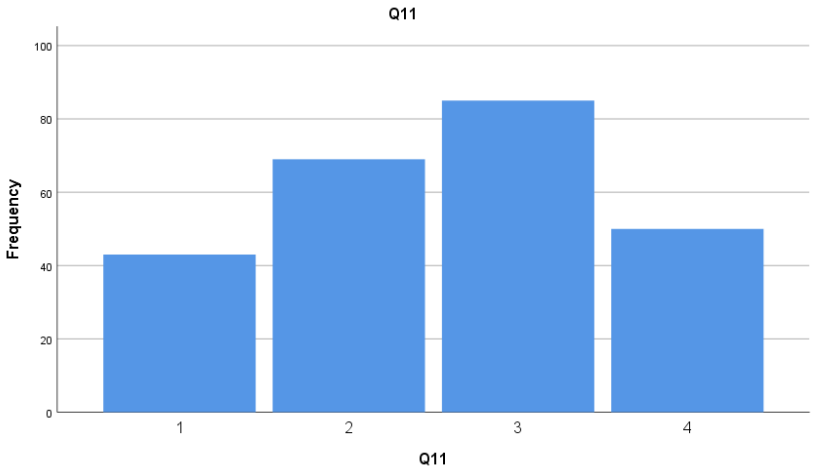
In the pre- and post-program survey results, we can see that before benefitting from the *Post-Discharge Program* services, over 38% of respondents disagreed or strongly disagreed that there were people they could depend on if they needed help. However, in the post-program survey results, just 9.5% beneficiaries of the *Post-Discharge Program* disagreed. Overall, *fully 90%* of those who benefitted from the *Post-Discharge Program* services felt that dependable help was available should they need it.

This represents an over 20% increase from the pre-program participants, representing an increase in social supports for those who engaged with the *Post-Discharge* program.

Comparably, Question 11 of the Social Provisions Scale also assesses for a shift in social supports available to respondents, this time through personal relationships.

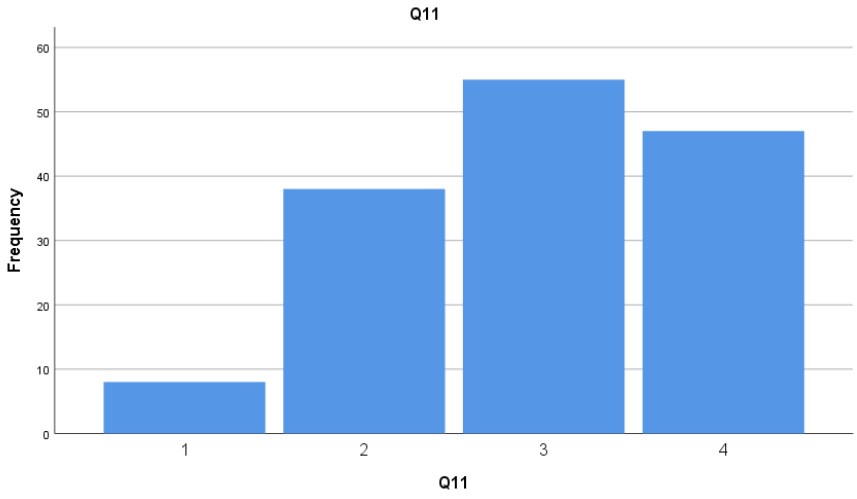
Q11: I have close relationships that provide me with a sense of emotional security and well-being.

Pre- survey responses



1 = Strongly Disagree
2 = Disagree
3 = Agree
4 = Strongly Agree

Post- survey responses

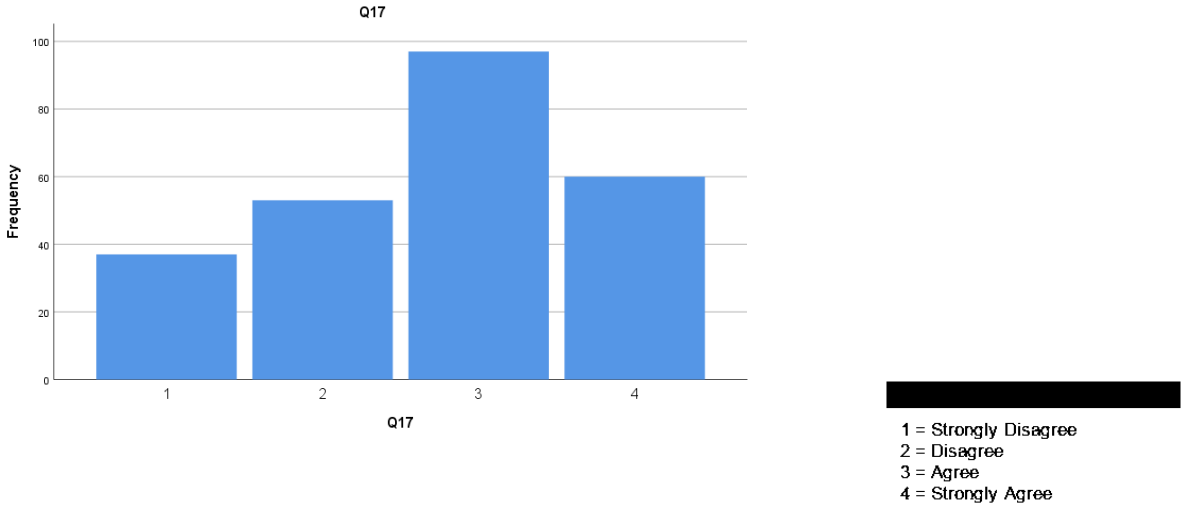


We can see that before benefitting from the *Post-Discharge Program* services, about 45% of respondents disagreed or strongly disagreed that they had close relationships that provided a sense of emotional security and well-being. However, in the post-program survey results, this had decreased to about 30%. Overall, over 60% of those who benefitted from the *Post-Discharge Program* services now felt they had one or more close relationships. Notably, in the

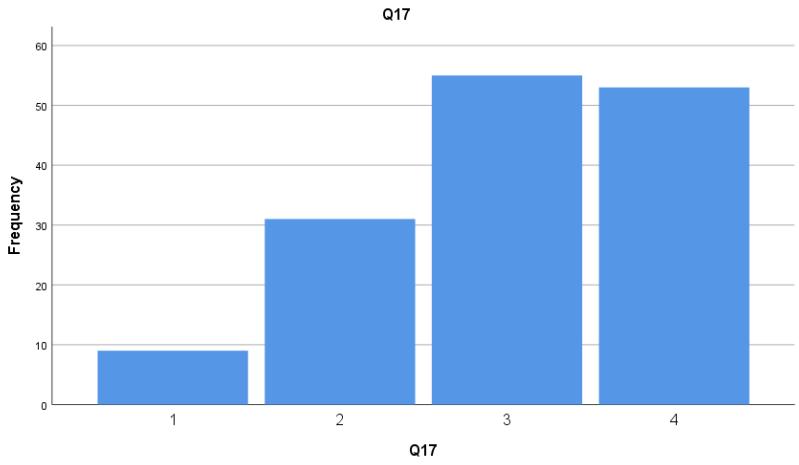
testimonials listed on page 26-237, many program users shared that their Friendly Visitor was a valuable relationship in their life, or had connected them to other ongoing service providers.

Question 17 of the Social Provisions Scale aligns with 11, above, asking service-users to reflect on the existence of significant social connections in their lives.

***Q17:** I feel a strong emotional bond with at least one other person.*
Pre- survey responses



Post- survey responses

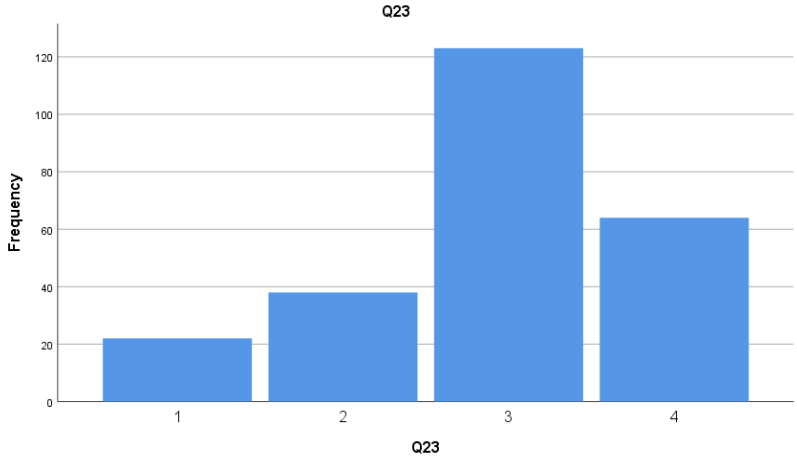


We can see that before benefitting from the *Post-Discharge Program* services, over 36% of respondents disagreed or strongly disagreed that they feel a strong emotional bond with at least one other person. However, in the post-program survey results, this had decreased to just over 25%. Overall, 73% of those who benefitted from the *Post-Discharge Program* services now felt a strong emotional bond with at least one other person. This marks an increase over 10% from the pre-program group.

Last, Question 23 of the Social Provisions Scale asks respondents to consider their social capital – that is, social connections and relationships that they can lean on in times of stress or crisis.

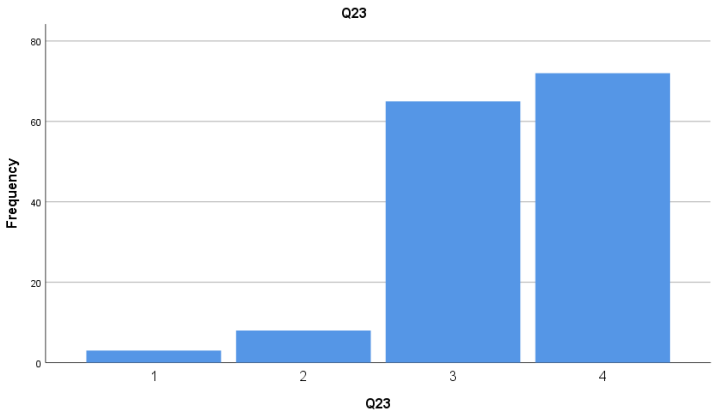
Q23: *There are people I can count on in an emergency.*

Pre- survey responses



1 = Strongly Disagree
2 = Disagree
3 = Agree
4 = Strongly Agree

Post- survey responses



Here, we can see the shift in responses visually. Before benefitting from the *Post-Discharge Program* services, almost 25% of respondents disagreed or strongly disagreed that there were people they could count on in an emergency. However, in the post-program survey results, this had decreased to just over 7%. Overall, 92% of those who benefitted from the Post-Discharge *Program* services now felt that there were people they could count on in an emergency. This marks an increase of 16% from the pre-program group.

Responses to this question are particularly important, as clients benefiting from the *Post-Discharge Program* services represent medically frail service-users, or those who have experienced a recent health issue that required hospitalization.

The shifts in perceptions of social supports in Questions 1, 11, 17 and 23, identify positive increases in scores on the Social Provisions Scale correlating to reducing social isolation. As per the *Connected People* OTF priority, this evaluation finds that the *Post-Discharge Project* is successfully address social isolation in its target client population. In this, the *Post-Discharge Project* is reducing social isolation.

Our evaluation tools – the survey for service-users (see Appendix E), client testimonials and the Social Provisions Scale -- have consistently found that people who are isolated now have connections in their community.

Post-Discharge: Project Targets

Project Targets are as follows:

- 175 seniors/ marginalized individuals referred per year
- Implemented and successful partnership model between hospitals and community agency that provides support for seniors and marginalized groups after hospital discharge
- Participants declare that they are well supported Post-Discharge Project and their needs are met though participation in community programs as a result of the project
- A summary of these targets are noted below, and analysed in the following chart:

Project Target	Target Details	Achieved?
175 seniors/ marginalized individuals referred per year	✓ The Project has a target of 175 patients referred (total for all three hospitals) per project year ✓ Between May 2017 and December 2018, Post-Discharge saw 612 service users (total # of Unique Clients who received a direct service through the Post-Discharge program) ✓ 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 5553 services delivered (services include initial contact, follow-up, referrals to other supports, friendly visitors visits and patient advocacy)	✓ Achieved ✓ Exceeded
Number of readmissions to the hospital	Project start to March 2018 total: 102 survey respondents March 2018-January 2019 total: 69 survey respondents ✓ In the above time frame, 167 clients responded to the question: *Were you re-admitted to hospital for any reason while receiving this service?* ✓ 23 were re-admitted to the hospital following their engagement with the Project services ✓ 144 were not re-admitted to the hospital following their engagement with the Project services	✓ Achieved ✓ A minority of clients (16% of those who responded to the evaluation survey) were re-admitted to hospital
Participants declare that they are well supported Post-Discharge and their	✓ 172 clients responded to the question: *I would recommend this service to others.*	✓ Achieved

needs are met though participation in community programs as a result of the project	✓ 125 respondents (or 73%) strongly agree that they would recommend this service to others ✓ 41 respondents agree that they would recommend this service to others ✓ 6 were neutral in response to this question	

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 as planned, and in accordance with its current structure (intake, intervention, referrals; Project staff and Friendly Visitor roles). This structure has thus far proven useful in both patient engagement and in the service experiences of immigrant seniors in Peel and Toronto. Testimonials of staff and service-users both note, however, that some clients require more than 3 months of services/Friendly Visits. With this in mind, the Evaluator recommends that intake and assessment staff continue with a client-centred and flexible approach to services. Where necessary, some service periods may be less than 3 months; in other, complex cases, services required may exceed 3 months.

More, having full-time *Post- Discharge* staff positions at Polycultural have fostered a strong foundation for *Post- Discharge* service provision: for example, staff offer coordination support to both hospital workers and Friendly Visitors, make strong client-Visitor matches, and maintain consistent data about project targets and client feedback.

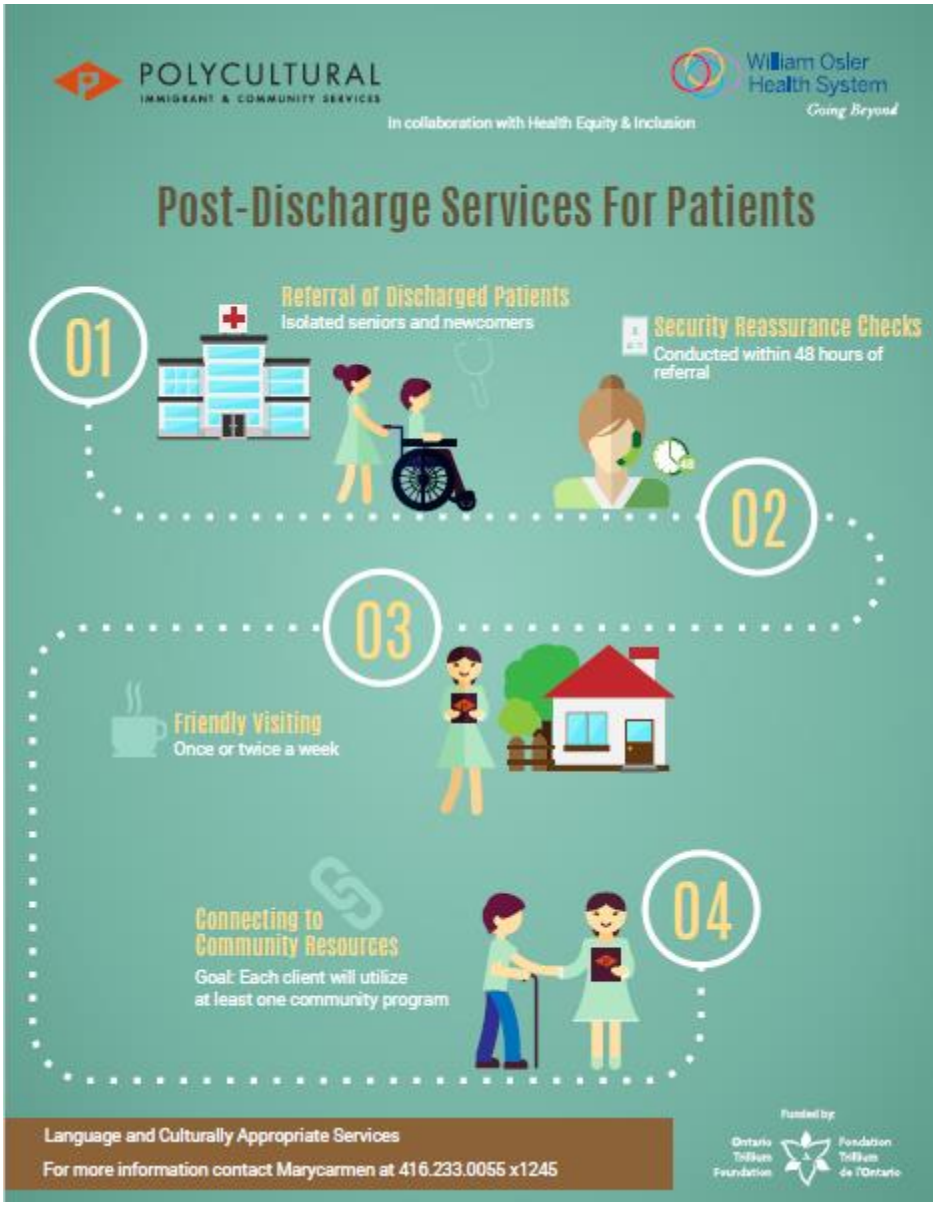
Project staffs and service-users made the following recommendations based on the project's first year, identifying the service's unique competencies:

- ✓ Continue the Friendly Visitor program (in-person visits to isolated seniors are extremely well-received)
- ✓ Continue to offer Friendly Visits in the client's first language (this has allowed immigrant seniors to directly engage with the service/Visitors, and also to bridge to other community and medical services)
- ✓ Continue to communicate with hospital partners to promote the project to foster ongoing referrals to the *Post-Discharge* services.

Last, this evaluation notes the possibility of growth for *Post- Discharge.* Trillium Health Partners is currently looking at a partnership to support the growth of the current *Post-Discharge* Project. Both Polycurltural and Dr. M. Backo-Shannon (Program Chief and Medical Director, Primary Care, Seniors Care, Palliative Care, Rehab, CCC) of Trillium Health Partners are currently meeting to consider the possibility of growing, and modifying the Project to be aligned with the THP and Mississauga Halton LHIN priorities. Building on the successes of the *Post-Discharge* Project so far, this would extend the Project's services into the communities served in Mississauga and surrounding area, with a focus on meeting the needs of older and medically frail immigrant community members.

Good work, Polycultural, on your work in leading the *Post- Discharge* Project thus far. This Evaluation finds that the project has successfully met its objectives and targets related to Project partnerships, patient engagement and experiences, and increasing competencies aligning with the Social Provisions Scale under the *Connected People* priority.

Appendix A: *Post-Discharge* Outreach Poster



Appendix B: *Post-Discharge* Referral Email (to health partner making referral)

Post-Discharge Program: Template, follow up referral e-mail

Dear [name of referrer],

Thank you for referring [name of patient] to the Post-Discharge Program. We have received your referral form and have contacted the patient. [Name of patient] has [enrolled into/declined to enroll into] the program.

If you have any questions about next steps, please contact us as a response to this e-mail.

Kind regards,

Appendix C: *Post-Discharge* Services Assessment Form

POLYCULTURAL
IMMIGRANT & COMMUNITY SERVICES

Post-Discharge Services – Assessment Form

General Information	
Name:	Date of Birth:
Provide details about client's family and social support (frequency of visits, community connections):	
Language Preference:	
Length of stay at EGH:	
Was this client's first hospital admission? If not, provide details:	
CCAC Attachment:	
Referred to:	

Attachment to Healthcare		
Does the client need…	**Yes/No**	**Provide Details**
A family physician?		
Assistance with medical appointments?		
Dental Care?		
Health Prevention education?		
Chronic disease management support?		
Medication reminders?		
Other, please specify		

Housing Needs	
Describe living arrangements: (Independent /assisted living, nursing home, apartment, house, seniors home)	

Does the client live with family members? Or Do family visit on a regular basis?	

Does the client require…?	**Yes/ No**	**Provide Details**
Housing support? (subsidised housing or other)		
In-home support? (Nursing care, occupational therapy, etc.)		
Home maintenance services? (Cleaning, repairs, etc.)		
Other? Please specify		

Financial Security	
Sources of income :	
Is the client in need of financial assistance? Provide details:	
Other needs? (Food, clothing, etc.)	

Personal Care	
Are there changes in physical activity/mobility post-hospitalization? Please describe	
Does the client require mobility assistance?	

Mental Health and Wellness	
Need:	**Comments:**
Language Learning and Ethnic Community attachment	
Need:	**Comments:**
Social and Recreational	
Need:	**Comments:**
Food and Nutrition	
Need:	**Comments:**
Physical Activity	
Need:	**Comments:**
Transportation	
Need:	**Comments:**

Appendix D: *Post-Discharge* Evaluation Tool (survey) for Health Professionals (partners)

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!

Appendix E: *Post-Discharge* Evaluation Tool (survey) for Service Users

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.

11. The person who contacted me/visited me at home was friendly, respectful and helpful.

Strongly Disagree				Strongly Agree
1	2	3	4	5

12. Because of this service, I was able to talk about and better understand my needs.

Strongly Disagree				Strongly Agree
1	2	3	4	5

13. I look forward to the friendly visits.

Strongly Disagree				Strongly Agree
1	2	3	4	5

14. After taking part in this service, I feel more independent.

Strongly Disagree				Strongly Agree
1	2	3	4	5

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

Strongly Disagree				Strongly Agree
1	2	3	4	5

16. After taking part in this service, I feel less isolated.

Strongly Disagree				Strongly Agree
1	2	3	4	5

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

Strongly Disagree				Strongly Agree
1	2	3	4	5

18. I would recommend this service to others.

Strongly Disagree				Strongly Agree
1	2	3	4	5

19. Did you require services and visits in a language other than English?
Yes ☐ No ☐ Language: _____

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

21. 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 the Evaluator for both the *After the Discharge Project* (Polycultural Immigrant & Community Services), the *Improving 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).

Since 2014, Nicole has been the Gender Specialist in Women's Support Network of York Region's Projects addressing human trafficking in York Region. 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 2015, 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 in a 2015 collection by Demeter Press.

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