The Evaluation Centre for Complex Health Interventions *Making Evaluations Matter*

Health Access St. James Town Phase II Evaluation Report

March 27th 2015

EVALUATION

Rethink,

Reshape,

Reform

This report is developed by a team consisting of Khanh Le, Emily Xi Chen, Sanjeev Sridharan and April Nakaima. The graphics and formatting of the report is done by Ian MacDougall.

Table of Contents

Introduction

Background

In 2010, a fire occurred in a residential building in the St. James Town neighbourhood, a densely population neighbourhood in Toronto. In the aftermath of the fire, community stakeholders became aware of the many residents who were experiencing barriers to accessing health and social services.

The Health Access St. James Town (HASJT) project began as a response to the fire in 2011. In phase 1, through engagement with service providers and residents, gaps in health and social services in the neighbourhood were piloted. By late 2012, some services that were not previously available were piloted: the Seniors' Mental Health Day Program, a primary care physician working on-site half day a week, a diabetes clinic, mental health counseling, a Men's circle, and a Mobile Dental Bus. Apart from the last two, all the services were delivered at the Community Corner, located at 200 Wellesley Street where the fire occurred. All services other than the Mobile Dental Bus continued into the second phase of the project. In addition, a standardized intake form was developed and the warm transfer process, described in later in this document, was piloted.

The second phase of the HASJT project began in April 2014, when leadership of the project was transferred from consultants to the Health Access Working Group (HAWG), a network of service providers tasked to steer the project. Sherbourne Health Centre is the lead organization for the HASJT project. 13 organisations are members of the Health Access Working Group.

There is recognition by health care providers and the Ontario provincial government that addressing the healthcare needs of "high needs and unattached individuals" would not only improve issues of inequities, but also manage the long-term costs associated to healthcare. The current thinking is that the health outcomes of this target group would be improved if interdisciplinary professionals and service providers integrated their services and provide coordinated care planning for their clients. This is described in the Minister of Health and Long-Term Care's Action Plan for Health Care released in February 2015, and exemplified in the creation of 69 Health Links, which are networks of providers committed to care coordination for individuals with complex and high needs individuals.

In the second phase, the HASJT project sought to carry out similar goals, but at the neighbourhood level, by working with community partners to improve access to isolated, high need, hard to serve and/or unattached individuals through coordinated partnerships and warm transfers.

The three key objectives for phase 2 included:

"1. Connecting isolated, high need, hard to serve and/or unattached individuals to relevant health and social services, thereby improving overall health of the community.

2. Improved access to health and related care through an active service coordination strategy involving intake and warm transfer processes and effective partnerships.

3. Planning a service delivery model that reduces barriers to accessing timely and appropriate care."

2. Evaluation Purpose

The evaluation report will document whether HASJT has met the three objectives described in its project charter for Phase II, listed in the following table, for the period from April 2014 to March 2015. Additionally, the evaluation report will be guided by three evaluation questions, also presented in the table below.

Project Objectives	Targets	Evaluation Questions	Sources of Information
1. Connecting isolated, high need, hard to serve and/or unattached individuals to relevant health and social services, thereby improving overall health of the community.	40 high needs TCHC/ CCAC clients and 60 newcomers and other high need clients will be connected to care.	How has phase II of the HASJT project contributed to understanding of complexity, and what does it mean to connect individuals?	Interviews with 11 clients Interviews with 5 project staff Interviews with 6 staff from partner organization 3 group meetings with HASJT staff Intake and service data Literature review
2. Improved access to health and related care through an active service coordination strategy involving intake and warm transfer processes and effective partnerships.	Clients have access to services in 15 different organizations through the warm transfer process. Clients are referred to system wide coordinated access entities as needed.	What are the role of active service coordination and effective partnerships in enhanced access, and has that coordination led to improved access to health care and social services?	
3. Planning a service delivery model that reduces barriers to accessing timely and appropriate care.	Work plan developed in consultation with the TC LIHN. At least 2 innovative service projects piloted.	What is the place-based service model used for coordination and partnership developments, and what are the strengths and limitations for reaching high risk individuals?	

3. Methodology

This evaluation uses a theory driven methodology. It starts with building a theory of change for the phase 2 implementation of HASJT. A theory of change describes the relationships between activities, outputs and short and long term outcomes (Kubisch et al, 2010; 1998).

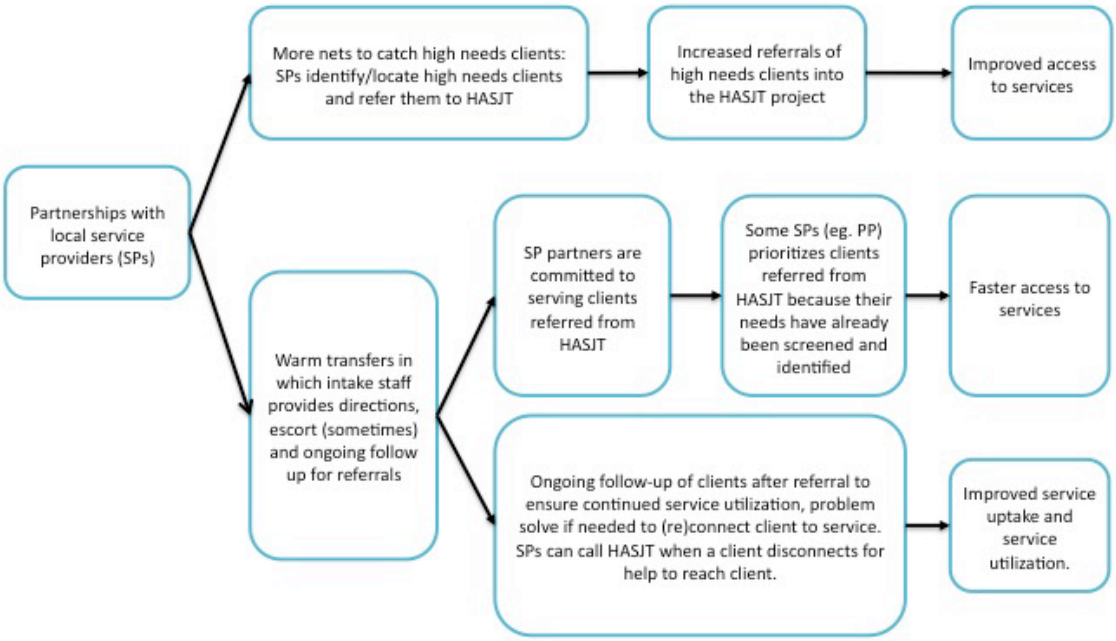
Pawson et al (2004, p. 4) provide a helpful description of what it means to think theoretically about interventions: ''Interventions are always based on a hypothesis that postulates 'If we deliver a program in this way or we manage services like so, then this will bring about some improved outcome' ... Interventions are always inserted into existing social systems that are thought to underpin and account for present problems. Improvements in patterns of behavior, events or conditions are then generated, it is supposed, by bringing fresh inputs to that system in the hope of changing and re-balancing it'' (Pawson et al., 2004, p.4).

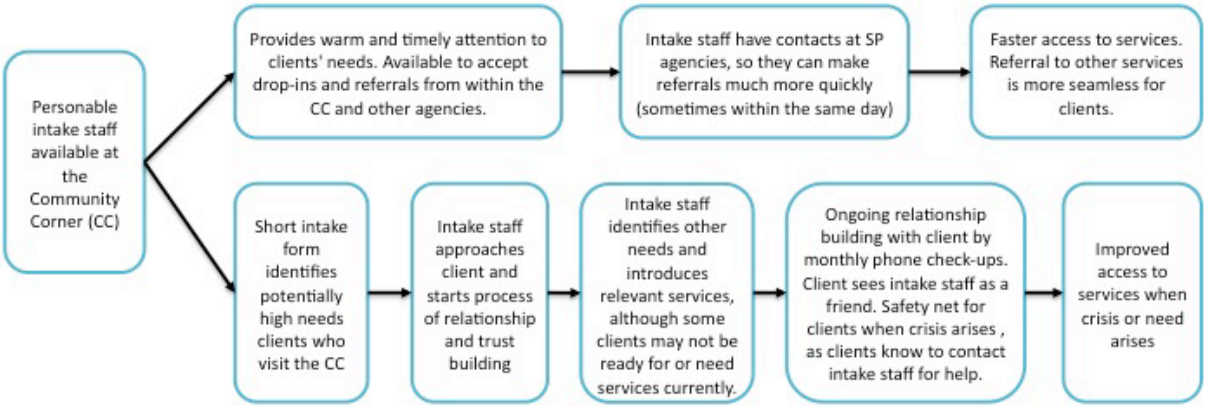
An initial theory that was developed for the Phase 2 is described below. The theory of change describes three pathways:

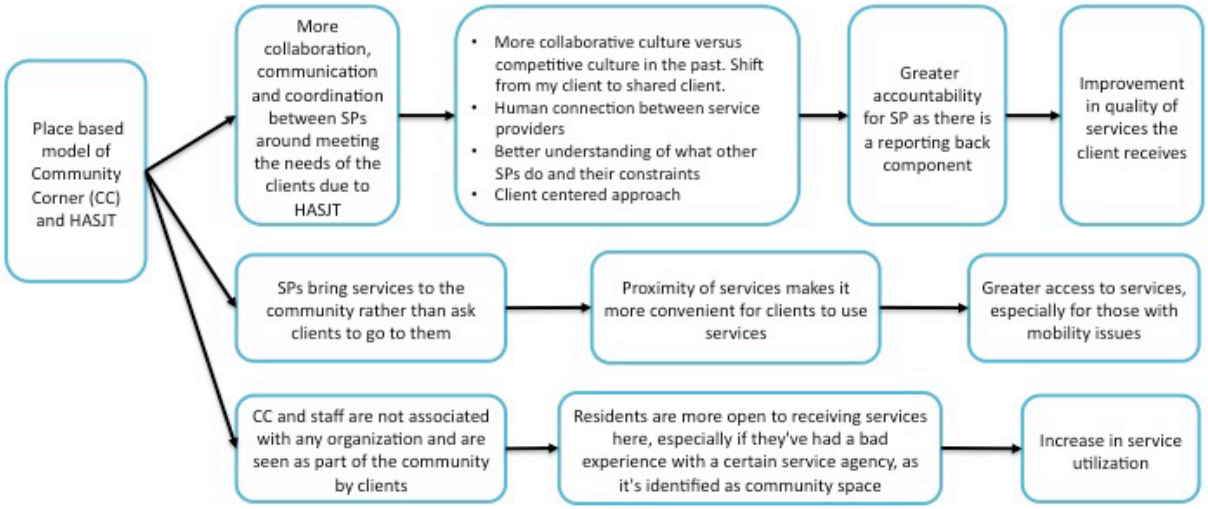
- Partnerships with Service Providers;
- Easy access to intake workers;
- Implementation of a place-based model;

Each of the pathways are described in greater detail in the figures below.

In September 2014, the evaluation team began discussions centered on developing a theory of change for the HASJT project. In subsequent meetings with the HASJT team, we spent time collectively reflecting on and evolving the theory of change to understand how the HASJT project brings about change relevant to its three objectives. The HASJT team, alongside the evaluation team, considered the indicators and evidence that are required to test different components of the theory of change. Data gathered and analyzed was then mapped onto the hypothesized change process.


Partnerships with local service providers (SPs)
More nets to catch high needs clients: SPs identify/locate high needs clients and refer them to HASJT
Increased referrals of high needs clients into the HASJT project
Improved access to services
Warm transfers in which intake staff provides directions, escort (sometimes) and ongoing follow up for referrals
SP partners are committed to serving clients referred from HASJT
Some SPs (eg. PP) prioritizes clients referred from HASJT because their needs have already been screened and identified
Faster access to services
Ongoing follow-up of clients after referral to ensure continued service utilization, problem solve if needed to (re)connect client to service. SPs can call HASJT when a client disconnects for help to reach client.
Improved service uptake and service utilization.


Personable intake staff available at the Community Corner (CC)
Provides warm and timely attention to clients' needs. Available to accept drop-ins and referrals from within the CC and other agencies.
Intake staff have contacts at SP agencies, so they can make referrals much more quickly (sometimes within the same day)
Faster access to services. Referral to other services is more seamless for clients.
Short intake form identifies potentially high needs clients who visit the CC
Intake staff approaches client and starts process of relationship and trust building
Intake staff identifies other needs and introduces relevant services, although some clients may not be ready for or need services currently.
Ongoing relationship building with client by monthly phone check-ups. Client sees intake staff as a friend. Safety net for clients when crisis arises , as clients know to contact intake staff for help.
Improved access to services when crisis or need arises



The evaluation used multiple sources of data, which are necessary given the range of evidence needed to assess the impacts of the project. For example, data on the number of referrals made is collected quantitatively whereas experiential data require qualitative evidence. In addition to project data such as the project database and high needs client journal entries recorded by the intake team, input from various stakeholders including the HASJT project team, partner organization staff and clients also informed this evaluation.

The evaluation team met with HASJT project team, along with the lead for the Community Corner, in a group setting several times between September 2014 and March 2015. A meeting with Lori Lucier, project funder from TC LHIN, also took place in February 2015.

In February and March of 2015, the evaluation team conducted individual interviews with various members of the HASJT team, including the Director, Intake and Client Engagement Lead, Hub Coordinator, Data Analyst, and the Outreach and Engagement Coordinator.

Staff from the following six partner organizations were also interviewed:

- Central Neighbourhood House

- Community Resource Connections of Toronto (CRCT)
- Progress Place
- Sherbourne Health Centre
- Thorncliffe Neighbourhood Office
- Toronto Community Housing Corporation

Additionally, the evaluation team conducted 11 individual interviews with HASJT clients referred by the Intake and Client Engagement Lead and who were considered high needs in February and March. Through discussions with the clients, we explored their experiences with the HASJT project, which aspects of the project they found valuable, the quality of referred services, the project's impact on their health/well-being, and in what ways the project can be improved. The interviews also provided an opportunity to gain a deeper understanding of the manifestations of complexity.

High needs client journal entries recorded by each Intake Worker and the Intake and Client Engagement Lead were also reviewed. Each member of the intake team chronicled the high needs client they worked with from their first encounter and updated the entries as they follow-up with the client. Journal entries were implemented in Phase II to document and illustrate the process of locating, engaging, and connecting high needs clients to health and social services, complementing the data captured by the intake form. The entries also details barriers in the process as well as strategies used to address these challenges.

4. Evaluation Results/Findings

4.1 Objective 1

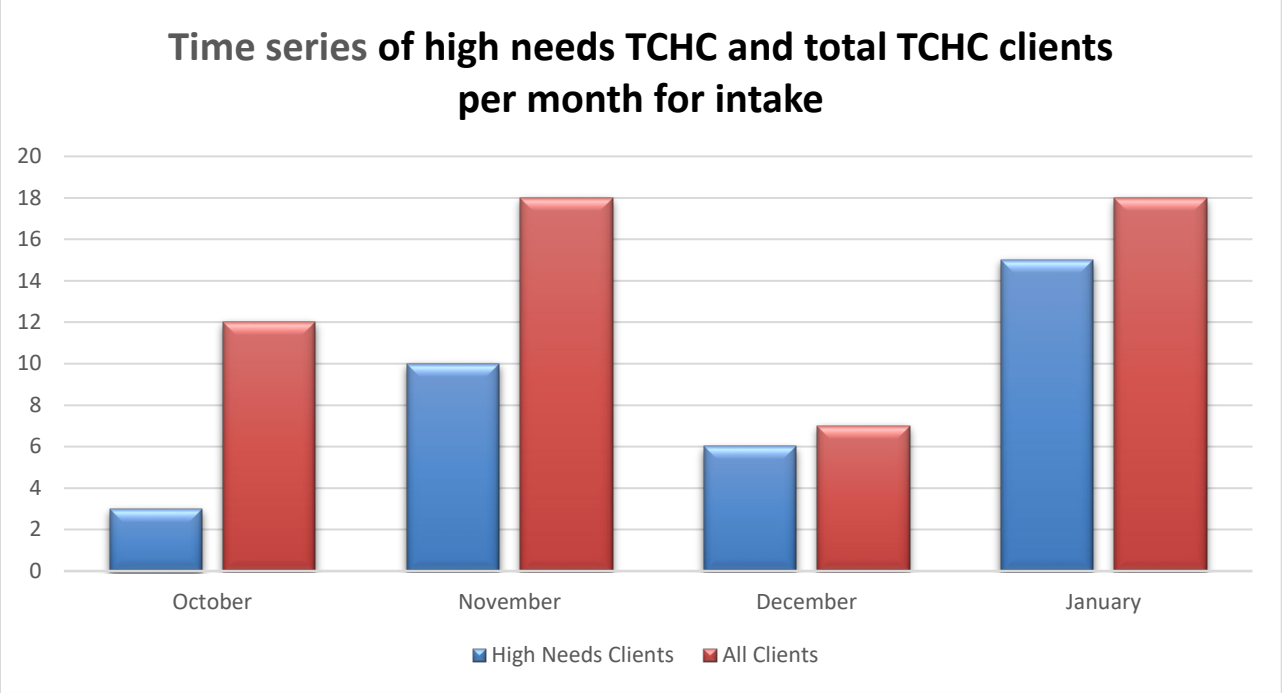
The targets

The first objective of Phase II of the HASJT project is **"Connecting isolated, high need, hard to serve and/or unattached individuals to relevant health and social services, thereby improving overall health of the community."** The targets for this goal were 40 high needs clients, who are either residents of a Toronto Community Housing Corporation (TCHC) building or clients of the Community Care Access Centre (CCAC) and 60 additional high needs clients including newcomers that could be connected to care.

The evidence

Between April and December 2014, the HASJT team reported that 55 high needs clients and 154 newcomers (immigrants who have been in Canada for less than three years) and other high need clients were connected to services.

In February 2015, the evaluation team reviewed the intake and service data for high needs clients for the period from October 2014 to January 2015. We were informed that the data, particularly around descriptions of complexity, was in the process of being defined prior to October 2014, and with the hiring of the data analyst staff in September 2014, the definition was completed. Also, to assess whether high needs clients have been served, the evaluation team looked at the journal entries created by HASJT staff.



The evaluation team reviewed journal entries recorded by the intake worker for 44 high needs clients, served from July 2014 to March 2015. The intake staff recorded social demographic details (e.g. age, gender, and racial background), basic assessments of the client needs, the clients' opinions of suggested services, follow-up communication with clients, and service coordination with other service providers, if there were any.

Of the 44 journal entries reviewed by the evaluation team, more than three-quarters of the clients had one or more health problems. At least half the clients self-reported or were assessed by the intake staff to have a mental illness. And, about one-quarter of the clients documented in the journals had more than one health issues. About five individuals reported some visits to the Emergency Department, with frequency ranging from three times in a month to ten times in a year.

According to the data provided by the HASJT team, 209 referrals were made for high needs and newcomer clients from April to Dec 2014. The evaluation team was not able to determine the quality of referrals. In order for the evaluation team to determine if these referrals were appropriate, needs assessment data must be recorded by HASJT staff and mapped to the referred services for each client. This data was not available at the time of the evaluation. However, we asked eight clients whether their needs were met through the referrals through HASJT. Six of the clients felt their needs where met, one did not answer, and another said that while suggested services may be appropriate, the individual consciously chose not to accept services.

Several of the clients provided very warm feedback about the Intake and Community Engagement Lead (ICEL). When describing the details of what it is specifically about the ICEL that they valued and made a difference, almost all of these clients noted her focus in making them feel comfortable. One client described the ICEL as being like a "hostess - warm, welcoming, supportive, sincere, and genuine." He contrasts her conduct to the brief and impersonal "hey, how are you, have a seat" experience that he has experienced elsewhere. After the encounter with the ICEL at the Community Corner, he felt the Community Corner is a place he'd like to come to more frequently. Other clients appreciated how enthusiastic and passionate the ICEL is about helping residents. Several clients spoke about the ICEL as a friend, someone who cares, who they can talk to, is understanding, is a good listener, and willingly offers her assistance. A few clients also noted that the information the ICEL provided about potential services were very helpful.

Learnings from the project for Objective 1

Through interviews of clients, project staff and service partners, the evaluation team sought to develop an understanding of ***how has the current phase of the project contributed to understanding of complexity, and what does it mean to connect individuals?***

The Toronto Central LHIN states that complex and at-risk populations are the high cost users of the health care system. Among the 5-10% of the highest cost users were individuals who had diseases relating to the circulatory, blood and lymphatic, respiratory, and digestive systems. Among the high cost users were a high proportion of people who access the emergency department for mental health, digestive and circulatory disorders.[1]

In 2012, Schaink et al. carried out a scoping review of what patient complexity is in the context of providing health services and/or outcomes. They reviewed 127 relevant articles and found references of complexity as referring to individuals having chronic health conditions plus one or more of the following characteristics: medical/physical challenges (e.g. taking multiple medications, mental health challenges, psychological distress, substance use); social health issues (e.g. caregiver strain, poor social support, relationship strain and lack of leisure time); experiential challenges (e.g. poor quality of life, difficulty navigating services and the need for a care manager, lack of access to providers, and higher healthcare costs); and demographically associated disadvantages, such as by age (e.g. advanced age and frailty), gender, poverty, ethnicity, and lower levels of education.[2]

The HASJT team viewed complexity more broadly than health problems, and included social determinants of health in their definition of high needs. The project recognizes that social factors, and not simply health factors alone, are important in influencing health outcomes. The table below summarizes some of the work that has been done by the HASJT team in developing a complexity ranking tool.

Summary of the development of the complexity ranking tool

The complexity ranking tool is a method to determine a client's complexity based on the social, economic and health information provided at the time of intake and recorded from the Intake Form.

- The first version of the complexity tool was developed in September. One

[1] Toronto Central LHIN (2013). *Enhancing Capacity to Connect Complex and At-Risk Clients to Services to Increase Access, Improve Coordination, and Enhance Care Management*.

[2] Schaink, A., Kuluski, K., Lyons, R., Fortin, M., Jadad, A., Upshur, R. ,Wodchis, W. (2012). A scoping review and thematic classification of patient complexity: offering a unifying framework. *Journal of Comorbidity* 2012;2:1–9

point was assigned for each category in which a client met the high-risk conditions: 1) Living situation (choices were: lives alone, lives with others, no fixed address, temporary address, or lives with immediate family), 2) Income source (OAS, ODSP, or OW), 3) Type of housing (Shelter or TCHC), 4) Without informal/formal support (CCAC, PSW, TCHC, other), and 5) Health condition (physical, chronic, mental - up to 3 points).

- The HASJT team noted that the scoring for living situation was subjective and depended on the intake worker's assessment of whether the living arrangement provided support to the individual. Furthermore, physical health and mental health status information was not often available at the initial intake meetings.

- A client with a score of 3 or more would be considered complex and reported as high needs. Based on this method, 55 high needs TCHC clients were identified from April 2014 to December 2014.

- In January, the HASJT team tested a revised complexity tool using a weighted ranking method. This method placed differential weighting for the 5 criteria above, accounted for multiple health issues and included ED visits as a measure of complexity. This will be the new algorithm that will be implemented in the new fiscal 2015-2016.

HASJT identifies high needs in terms of the clients' living situation (living alone), type of housing, income source (social assistance such as ODSP, OW and OAS), presence of informal (living with a family member) or formal support (connected to a service provider, e.g. CCAC or case worker), and whether there are mental and/or physical health issues.

One staff from a partner organization emphasized that while a high needs individual may have multiple health issues or co-morbidities, it is also possible that a high needs individual may just have one issue. An individual may have a severe and persistent mental illness but because of their social and economic situation, their lives are hugely and negatively impacted by it. Due to the complexity or severity of issues, the individual may not know where to go for help.

Often, staff of the HASJT team and partner organizations use the term "isolated" in conjunction with high needs. One staff at a partner organization described that isolated individuals are people who don't go often outside of their homes and who don't ask for help. One client, who is also a HASJT Community Ambassador, made a similar observation that people who need help the most and those who are most isolated don't ask for help.

Based on our interviews with clients and staff of HASJT and partner organizations and analysis of journal entries, people tend to not ask for help for a variety of reasons: 1) past negative/ traumatic experiences with the social/ health services system; 2) they see themselves as independent and self-reliant; 3) they have a mental illness that

makes it difficult for them to leave the house or interact with other people; 4) they do not think they need or know to ask for help until their health condition deteriorates drastically or a crisis happens, at which point they have no choice but to ask or accept help. According to a staff member from a partner organization, crisis that would trigger an isolated individual to ask for help or accept help could involve a psychotic episode, a threat of eviction (often due to hoarding), or uncontrolled addiction. Of 44 clients identified in the journals, 3 were at risk of eviction, 4 were noted with addiction issues, and 1 with an addiction and facing eviction.

Given that a complex, high needs and isolated individual may not know where to start to ask for help and may be unwilling to ask for help, staff from HASJT and partner organizations independently articulated that the sooner an isolated individual with complex needs gets the help they need, a crisis may be prevented or their health conditions may be better managed or prevented from rapid deterioration. When such an individual asks for help, the service provider must seize that opportunity by immediately listening to their needs. When the individual asks for help and doesn't get it immediately, they may change their mind about accepting help within a few days.

The staff at the community partner organizations said that HASJT intake staff are available and responsive, whether they are at the Community Corner, at an outreach event in a building lobby, or during a home visit with TCHC staff. Likewise, two staff members from the partner organizations said that the HASJT intake staff have worked with the partner organizations to fast track cases to get the people help right away.

Another question that the evaluation explored was: ***When does a service referral lead to a "connection"?*** One service provider said "connectedness" depends on what the client hopes to get from the program, what they would like to accomplish and how often they want to engage with the service. Some people don't set goals, but if they are attending as frequently as they wish to do so, they are connected. If they stop coming, maybe due to sickness, they are disconnected. People with complex needs may never stop needing a high level of support as they may have life-long issues.

The same staff member from the partner organization said that an individual with complex needs may have issues that are evolving because their needs would change over time, i.e. at one time it's a physical health issue, at another type it's a mental health or addiction issue, or a different physical health issue. HASJT tries to make the connection ongoing, and for this reason HASJT gets a lot of repeat clients.

Summative Assessment of Objective 1:
"Connecting isolated, high need, hard to serve and/or unattached individuals to relevant health and social services, thereby improving overall health of the community."

- The evaluation team was not able to assess whether the referred services have led to overall health of the client and the community, as stated in Objective 1. ***However, following the logic of the theory-driven approach,***

the evaluation concludes that the implementation is very much on the right track.
(Please note: Any notable health changes to clients would require a long period of monitoring that is not possible within the timeframe of Phase II. Likewise, any measure of improvement regarding the health outcome of the community would require a longer timeframe and a larger evaluation scope).

- A learning culture around addressing the needs of the most marginalized has clearly emerged among HASJT leadership and staff. The evaluation team witnessed multiple learning sessions around understanding of the contexts and mechanisms of what it takes to reach the most marginalized.

- Such a learning culture is especially discernible in the multiple evolving discussions/dialogues that the HASJT team have had around defining a complex client.

- The focus of the HASJT team in developing relationships and ongoing engagement with high needs clients is especially laudable.

4.2 Objective 2

The targets

The second objective of the HASJT Phase II project is: **"Improved access to health and related care through an active service coordination strategy involving intake, warm transfer processes and effective partnerships."** The two corresponding targets were: 1) Clients have access to services in 16 different organizations through the warm transfer process, and 2) Clients are referred to system-wide coordinated access entities as needed.

Evidence

All client referrals to service provider partner organizations are conducted through the warm transfer process. This process involves identifying appropriate services based on client's needs, setting up the first specialist appointments, giving clients directions, providing reminders, sometimes escorting clients and following-up after referrals.

As of February 2015, HASJT includes 16 service provider partners. The five partnerships developed in Phase II were with Anishnawbe Health Toronto, Toronto Public Health, Coordinated Access to Care from Hospital – Emergency Department (CATCH-ED), Toronto Community Care Access Centre (TC-CCAC), and Regent Park Community Health Centre. These new partnerships were sought and built strategically to address service gaps and broader access issues identified by the project team and the Health Access Working Group (HAWG).

The HASJT intake team said that they had difficulty connecting Aboriginal residents to culturally competent services. They identified Anishnawbe Health Toronto as a potential partner as this community health centre offers programs and services using traditional approaches for the Aboriginal community. The Lead of the HASJT then made the connection with the leadership of Anishnwabe to initiate the partnership. The partnership with Toronto Public Health stemmed from the HAWG identifying broader access issues and the benefits of having partners with city-wide scope who can contribute to community development. Similarly, a partnership with TC-CCAC and CATCH-ED was recently established in response to the need for referrals to system-wide coordinated access entities. TC-CCAC connects Toronto residents to quality community-based and home-based health care and resources. CATCH-ED is a program that seeks to decrease preventable emergency department visits and improve access to care for frequent ED users to meet their mental health, addiction and other health needs. CATCH-ED has existing partnerships with several community mental health agencies and Community Health Centres to which frequent ED users can be referred for appropriate care.

Partnerships with the two system-wide coordinated access entities, TC-CCAC and CATCH-ED, have been established in the first and second quarters.

Learnings from the project for Objective 2

This section explores the evaluation question: ***What are the roles of active service coordination and effective partnerships in enhanced access, and has that coordination led to improved access to health care and social services?***

Many HASJT staff and service provider staff agreed that consistent staffing is necessary to maintain partnerships as well as for service coordination, and that this would require funding for permanent positions. The Health Access Working Group meetings which are held monthly also contribute to sustaining partnerships, however staffing resource constraints of an interested agency prevented them from being involved. The HASJT project has recently reviewed intake and referral data to identify how to better engage and utilize partnerships at the table. This data has been shared with the Health Access Working Group and discussions with specific partners have been initiated at the leadership level.

Building and maintaining strong partnerships with organizations that provide services in St. James Town expands the reach to more high risk clients. Partner organizations such as Progress Place, Toronto Community Housing Corporation (TCHC), and Community Resource Connections of Toronto (CRCT) often serve clients with multiple needs and can refer these clients to the HASJT project when the client has needs beyond the scope of their practice.

The warm transfer process is a key component of the HASJT project. As example, one HASJT team member claimed that "in the past, referrals were not meaningful as service providers simply gave clients information and it was left to the individual to make the connection." This statement was validated by a number of partners. As example, a TCHC worker made the following observation: "Usually a provider makes a referral for a

client, and the service provider calls back needing to talk to the client. It's a very convoluted process for some individuals who have apathy about getting out, or for other individuals who want to resolve problems on their own and think accepting assistance is a mark on their character or makes them less of a person. HASJT is not just about referrals. With HASJT, the staff makes the direct calls to their contact at the service providing agency, then calls the client back to follow-up and problem solve if the referral doesn't follow through."

Warm referral involves the intake staff booking initial service appointments, giving clients directions, providing reminders, and sometimes escorting the clients, and conducting follow-up even after referrals are made. These efforts are especially helpful for clients who don't have telephones (so specialist may not be able to call them to inform them of the date of their appointment) and who tend to forget appointments made too far in advance.

The Progress Place staff interviewed noted that HASJT intake staff collect the required client information and share that information with relevant service providers. Therefore, the receiving organization does not need to repeat the intake process and the received information allows for more immediate confidence that the referral is appropriate. For example, clients referred to Progress Place from HASJT could become a member the same day the HASJT intake took place because Progress Place trusts that the client is eligible and referral would be a good match.

Another service provider explained, when making referrals, the HASJT intake staff directly calls their contact at the recipient organization. Previously, an intake worker would make a referral, wait for service provider to call back, and the service provider then would need to talk to the client to arrange the initial assessment. The warm transfer process shortens the time gap between referral and service delivery. Unfortunately, data detailing the time lapse between needs assessment to referral to service utilization is not available for the evaluation team to validate.

During the Progress Place interview, the staff mentioned that if a client were to miss their first or subsequent appointments, the service provider would inform the intake staff from HASJT. The intake staff then would try to seek the client out through calls or home visits and problem solve to reconnect the client. Warm transfers prevent clients from "falling through the cracks" if they become disconnected from services.

The HASJT experience has helped in reshaping established processes and mechanisms to make them more client centre and close working relationships with partner organisations has enabled this. There was a client with addiction issues. However he did not have a phone, and needed to be seen by counselor. Hence the usual process of the mental health intake of the organization calling the client and fixing an appointment was not possible. If regular process was to be followed, this client would fall through the cracks. So the ICEL presented the situation to the partner organization providing counseling, and after discussion, a system was created where such high needs clients could access counseling on a drop-in basis when needed on those days that the counselor was present at the CC.

Summative Assessment of Objective 2: : "Improved access to health and related care through an active service coordination strategy involving intake, warm transfer processes and effective partnerships."

- Strong empirical support was found for this objective being attained. The partnerships are developing in a strategic manner, targeted at meeting the needs of high needs and marginalized individuals.

- While partnerships take time to mature, trust is clearly being nurtured between organizations. There is early indication that inter-agency transfer processes are facilitating greater access for high needs and marginalized individuals and that processes are better able to catch the clients who otherwise might fall between the cracks.

- A future evaluation needs to explore how such networks and partnerships confer specific benefits to the lives of clients.

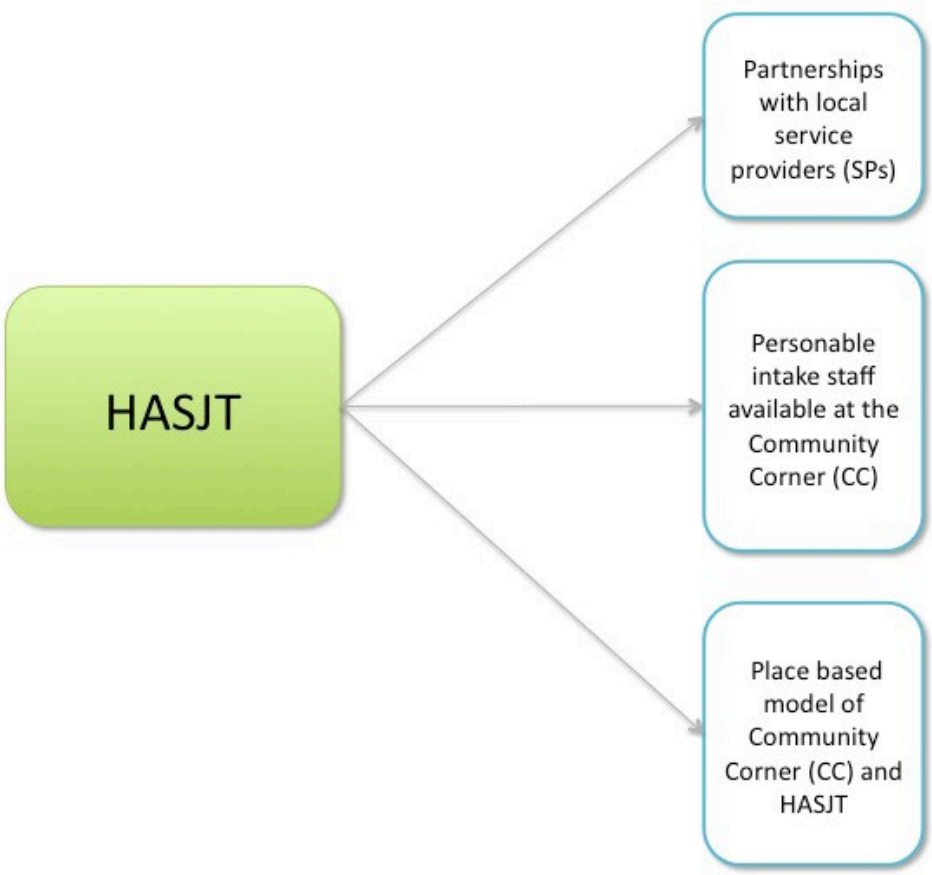
4.3 Objective 3

The targets

The third objective of the HASJT Phase II project is **"Planning a service delivery model that reduces barriers to accessing timely and appropriate care."** The two targets for this goal were: 1) work plan developed in consultation with the TC LIHN and 2) at least 2 innovative service projects piloted.

Evidence

As a part of the evaluation, a theory of change has been developed in collaboration with the HASJT project team. The theory of change is described in the three figures in Section 3 of this report. The theory of change provides one representation of the service delivery models that have been developed to promote access. A simplified view of the mechanisms by which HASJT seeks to work is described in the Figure below. The Appendix describes in greater details the mechanisms by which each of the pathways are hypothesized to work.



The model also encompasses HASJT staff providing intake and assessments in other sites based on a schedule. These include shelters, Rose Avenue Public School and other sites in St. James Town.

The two innovative service projects that were piloted in Phase II of HASJT were the partnerships with TCHC and CATCH-ED. (The CATCH-ED partnership has been described in the previous section).

As noted by several project staff, the partnership with TCHC is an innovative avenue for identifying high needs individuals. Specifically, HASJT staff mentioned that this partnership has been helpful in identifying isolated individuals and those with mental health issues (commonly present in clients at risk of eviction due to hoarding, for example). The TCHC and HASJT staff described the process: TCHC resident engagement workers flag high needs residents through regular safety audits and subsequently refer them to HASJT. When residents are reluctant to follow through on the referral, the TCHC worker invites HASJT intake staff to accompany the TCHC staff on home visits; the intake worker then would introduce services to these flagged residents. As reported by HASJT from October 2014 to December 2014, seven referrals have been made by TCHC to the HASJT project. Of these seven, we interviewed one client. He mentioned that he was aware of the Community Corner but never visited due to mobility restrictions. Through a home visit by the HASJT Intake and Client Engagement

staff with the TCHC staff, he was introduced to services that are available and suitable for him. He since has been connected to a personal support worker from CCAC, a nurse, and a social worker from CRCT.

Learnings from the project for Objective 3

Through group meetings with project staff and individual interviews with clients, project staff and service partners, the evaluation team delved into the following questions: ***How is the place-based service model conducive for coordination and partnership development, and what are the strengths and limitations for reaching high risk individuals?***

The Community Corner is located at the main floor of 200 Wellesley and serves as the base for the HASJT project. The service partners were asked about whether the place-based service model of the Community Corner was beneficial for service coordination and partnership development. All were in agreement that this place-based model was valuable. One service provider explained that the Community Corner is not just a co-location model where services are aggregated together. The co-location serves as a means of enhancing communication and collaboration between service providers and aids client transitions between services. She noted that the Community Corner provides a "no-wrong door" approach so that no one would fall through the cracks, regardless of which service provider organization made the initial contact or who would eventually provide the services. Another service provider staff member stated that sharing a common space is changing the way service agencies interact with each other. Along with another service provider and a HASJT staff, this staff person noticed a shift in perspective among the service providers from viewing clients as "my client to our client." Service providers have also noticed a change from a competitive culture to a more collaborative culture within the past year.

In group meetings with the HASJT team, interviews with service providers and interviews with clients, many interviewees commented on the importance of offering services near residents within St. James Town. In a group meeting, one project staff member mentioned that the HASJT project has influenced organizational culture by bringing services to the community rather than asking clients to go to them. Several partner organization staff spoke about the proximity of the services allows clients to more conveniently access these services, overcoming distance-related barriers to accessing services. One service provider staff person commented from her experience working with TCHC residents that for some individuals it is too taxing mentally, emotionally and physically to walk a few blocks to use services. This is reflected in the observations of another service partner staff whose agency began offering health promotion classes at the Community Corner. When these classes had been offered at their location about 15 minutes away, no one attended; however several residents began attending after the class was offered at the Community Corner.

None of these service partner staff felt there are any limitations or problems of the place-based service model for reaching high risk individuals. One specifically commented that logistical issues such as not having enough space has not been a problem at the Community Corner.

Twenty Community Ambassadors (CAs) recently have been hired and received standardized training as a part of the project's evolving outreach strategy. All CAs are SJT residents and reflect the rich diversity of the neighborhood in language, ethnicity, age and other characteristics. CAs are an example of HASJT leveraging the existing strengths of the community as many of these individuals already had been volunteering for organizations in the SJT area. CAs will be mainly responsible for outreach activities in SJT buildings, including lobby outreach, and each CA will be responsible for outreach at two of the SJT buildings. The long term goal is for building superintendents and workers to know CAs in their building and connect high needs residents to the CAs. Outreach activities involving CAs will be initiated in April 2015.

Summative Assessment of Objective 3: "Planning a service delivery model that reduces barriers to accessing timely and appropriate care."

- A service delivery model that focuses on enhancing access has begun to be implemented, but we anticipate that it will go through iterative changes/ development in the next year. Figure 1 provides one representation of such a model. A key defining feature of this model is its focus on the needs of isolated high risk individuals. A key mechanism, by which this model works, is relationship building and reducing relationship barriers.

- While the initial empirical support for such a model are very promising, this model still needs to be formally tested in the next phase.

Appendix 1: Individuals Interviewed

HASJT Project Team:

- Nalini Pandalangat (Sherbourne Health Centre - Project Lead)
- Suja Stanly (Data Analyst)
- Amna Syed (Outreach and Community Engagement Coordinator)
- Nayanthi Wijesuriya (Intake and Client Engagement Lead)

Staff from Partner Organizations:

- Christina Strang (Toronto Community Housing Corporation – Community Services Coordinator)
- Criss Habal-Brosek (Progress Place – Program Director)
- Eleanor Sevilla (Community Resource Connections of Toronto – Case Manager)
- Kurt Aydiner (Community Corner - Hub Coordinator)

- Lori Lucier (TC LHIN - Funder)
- Nivedita Balachandran (Sherbourne Health Centre - Health Promotion and Systems Specialist)
- Ravi Subramaniam (Thorncliffe Neighbourhood Office, Lead – The Community Corner)
- Veronica Macdonald (Central Neighbourhood House – Director of In-Home Services)

Eleven high needs HASJT clients identified by the Intake and Client Engagement Lead.

Pathways of Influence of the HASJT Interventions in Phase 2

Chain 1 – Partnerships With Local Service Providers

Building and maintaining strong partnerships with local service providers (SPs) expands the reach to more isolated and high needs clients and improves access to services. The collaboration with nearby partner organizations provides an innovative avenue of identifying and reaching high risk clients. SP partners such as Progress Place, Toronto Community Housing Corporation (TCHC), and Community Resource Connections of Toronto (CRCT) often serve clients with numerous needs and refers clients with needs beyond the scope of their practice to HASJT. SPs, such as the TCHC, also serve as a mechanism for locating potential high needs clients. TCHC resident engagement workers flag high need residents through regular safety audits and subsequently refer them to HASJT intake staff. Intake staff includes the Intake and Client Engagement Lead, two intake staffs, and placement students. Intake staff also attends home visits with TCHC staff to introduce services to these flagged clients. As mentioned by both the HASJT Intake and Client Engagement Lead and the TCHC staff interviewed, this partnership has been especially helpful in identifying and connecting isolated high needs individuals and those with mental health issues.

The warm transfer process is a key component of the HASJT project and is enabled through the strong partnerships and relationships between the HASJT team and local SPs. Warm transfers include not only directions but also escort (if needed) and follow-up with the client and service agency. This process was piloted in Phase I and has since been fully implemented in Phase II of the project for all referrals to HASJT's SP partner organizations. SP partners are committed to accepting and serving clients referred from HASJT. As noted by the PP staff and HASJT staff interviewed, SP partners trust and feel assured that clients referred from HASJT will be an appropriate match as the intake staff has already identified the client's needs and understand the capacities of the SPs well. As a result, some service provider partner organizations such as PP prioritizes clients referred from HASJT. This leads to faster access to services for clients. Furthermore, as elaborated by the PP staff and HASJT Director interviewed, prior to the implementation of warm transfers, clients often fall through the cracks if they fail to attend their first appointment, or discontinue with the referred service for any reason. As a part of the warm transfer process, intake staff follow-up with clients after referral to ensure service uptake and continued service utilization. If a client disconnects from a service, the HASJT intake staff will contact client and SP to problem solve and reconnect the client to services. SPs such as PP also appreciate being able to contacting the HASJT for help in reaching a client who has discontinued use. The ongoing follow-up by the HASJT intake team after a client is referred ensures greater uptake of the services and improved service utilization.

Chain 2 – Personable Intake Staff Available at the Community Corner

With high needs clients, warm and timely attention to their needs and access to services is crucial. The Intake and Client Engagement Leads and a SP staff explain from their experience, when these clients ask for help but don't receive it quickly, they may change their minds a few days later. Therefore, when an individual with complex needs voices their needs and asks for help, SPs must seize that opportunity by listening to their needs and connecting them to the appropriate services in a timely manner. Personable intake staff is present at the Community Corner (CC) to warmly welcome and meet with clients who drop in, and are referred from within the CC or from external partner agencies. Many interviewed clients shared in their appreciation of the warmth, sincerity, enthusiasm, or friendliness of the Intake and Client Engagement Lead who greeted them at the CC. Additionally, having strong relationships with front line workers at other agencies, allows intake staff to help clients they meet to then access services faster. A SP partner staff explained that the traditional referral process is very convoluted, requiring multiple calls between the referring agency, the service agency and the client. In contrast, HASJT intake staff can make direct calls to their contacts at the service agency and fast-track clients to SPs, resulting in faster and more seamless access to services.

All clients who visit the CC for the first time must fill out a short intake form that helps to identify potentially high needs clients. The availability of the intake staff at the CC allows for timely contact with the client and initiation of the process of trust and relationship building. Having built rapport with the client then allows the intake staffs to more comprehensively identify the needs of the client and introduce information regarding available services. Some clients may not always be receptive to or feel they need the suggested services right away. The maintenance of relationships with high needs clients through monthly phone check-ups is especially important in these cases. The relationship acts as a safety net for clients when crisis arises as the client now knows the intake staff is someone they can contact for help. From interviews, some clients relayed how much they value their friendship with the Intake and Client Engagement and have or would contact her for help in the future. Two clients specifically mentioned they felt safe to share the problems they are currently facing with this intake staff because they felt she cared about them as she always listened and offered support. The presence of a personable, compassionate and readily available intake staff leads to improved access to services when crisis or need arises.

Chain 3 - Place based model of the Community Corner and HASJT

The place-based model of the CC and HASJT facilitates improved quality, access and utilization of services. SP partner staff interviewed mentioned, as a result of the HASJT project, there has been more collaboration and communication among SJT SPs to collectively address the needs of the community. They have noticed, as a result, a less competitive and more collaborative culture among SPs and a shift in perspective from "my" client to "shared"/"our" client in the past year. One interviewee also

mentioned she valued the human connection she has developed with other SPs as a result of her participation in the HASJT project and others noted they have a better understanding of what other SPs do and their constraints. A SP staff explained, due to the presence of a reporting back component (in the form of monthly Health Access Working Group meetings or follow-ups on referred clients from the HASJT intake staff), there is greater accountability for SPs to best serve their clients. As a result this leads to improvements in the quality of services received.

Another component of the HASJT place based model involves SPs bringing services to the community rather than asking clients to go to their location. The CC, where many SPs are present at various times of the week, is conveniently located within a TCHC building in SJT. Several SP partner staffs, HASJT team staffs, and clients interviewed agree that the proximity of services offered at the CC makes it more convenient for clients to use services. This translates to greater access to services, especially for those who experience mobility issues. For example with Sherbourne Health Centre providing primary care services, diabetes, and counseling services at The Corner, many high need clients and newcomers have been connected to health services onsite through HASJT. The leadership of the CC and the HASJT work together to enable integrating the work of HASJT and the CC.

Additionally, because the CC is not identified with any specific organization, SPs believe residents identify this space as a community space, and therefore are more open to receiving services there by HASJT intake staff not associated with any particular organization. This is especially helpful when people have been frustrated or had an unfavorable experience with a specific service agency before. SPs relay this enables improvements in service utilization.