EAST EFFORT PROJECT

Evaluation Fiscal Year 2022-2023

June 26, 2023

Prepared by MCQ Group

What is the East Effort Project?

ENABLERS

Provide guidance and support. Ontario Health provides funding under the High Priority Communities Strategy. FHC is the lead agency supporting all levels of the East Effort Project.

DECISION MAKERS

Members of the steering committee along with FHC, are responsible for the planning and development of the infrastructure to support East Effort (EE).

(represents organizations that were engaged during all 4 phases and not exhaustive list)

PARTNERS

Responsible for delivery of services in the community, addressing health inequity.

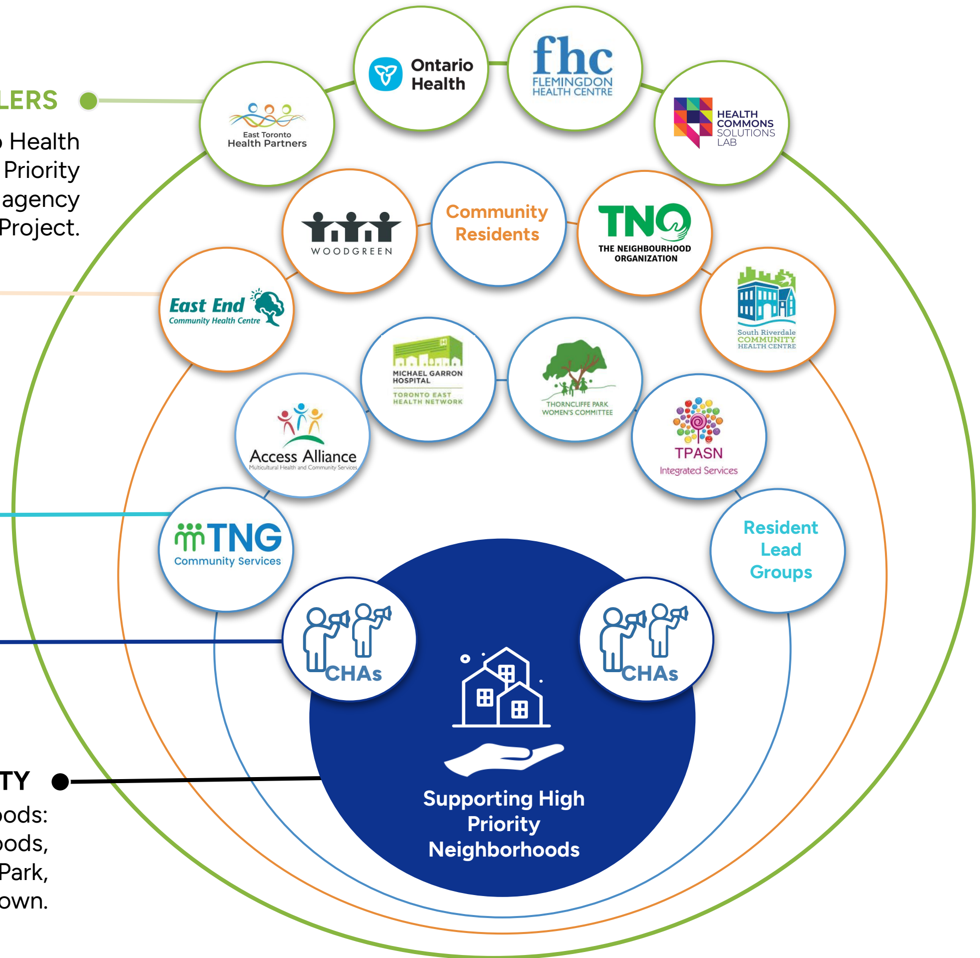
(represents organizations that were engaged during all 4 phases and not exhaustive list)

CHAs

Community Health Ambassadors (CHAs) are connectors to the community, leading outreach and engagement. They are employed by various Partner organizations.

COMMUNITY

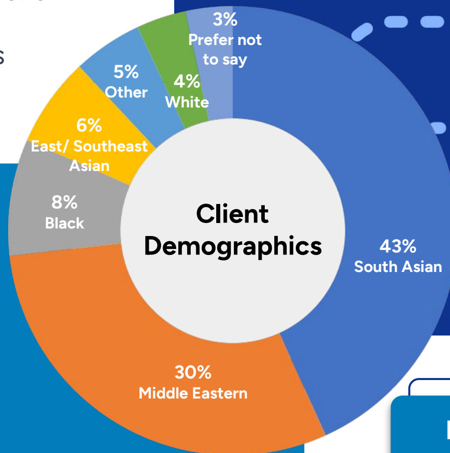
East Effort (EE) focuses on supporting these neighborhoods: Oakridge, Warden Woods, Flemingdon Park, Thorncliffe Park, Taylor Massey & Crescent Town.



East Effort In Action

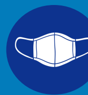
Population served:

Low-income equity deserving populations including: seniors, single mothers, immunocompromised people, families with disabilities, newcomers and racialized communities.



Service Navigation & COVID Support

2,907 Vaccinations
113% of Target



23,740 PPE distributed
14,437 RATs Distributed

614 referrals to community assessment centres/prescribers

Service Navigation

6,187 Referrals
154% of Target[1]

Wraparound Supports

4,012 Direct Support
212% of Target[2]

1. Wraparound Supports include: Housing, Food Security, Income Support, Social Services, Reminder Calls, Settlement Services, Transportation, etc).
2. Targets were self-determined.

Community Engagement, Education & Information Sharing

35 CHAs deployed in their local communities

53,938 Community Interactions

14,179+ 1-1 Interactions

995+ Educational Session Attendees

meeting the community where they are...

- CHAs are local residents
- Door-to-door outreach
- Wellness check-ins
- Local whatsapp groups
- Resident tabling sessions
- Wellness fairs & community events
- Flyer distribution

Cultural Sensitivity & Language Diversity

English, Dari, Urdu, Slovak, Bengali, Arabic, Pashto, Amharic, Tamil, Hindi

Increasing Access to Care

Primary Care

- **119** Primary Care Referrals
- **78** Newly Attached Patients

Preventative Care

- **60** HBA1C Screening Referrals
- **14** HBA1C Tests Completed
- **44** Retinal Screening Referrals
- **14** Retinal Screenings Completed
- **157** Mammogram, FIT & PAP Referrals

Mental Health & Addictions

- **9** Addiction Referrals
- **369** Mental Health Referrals
- **75** Mental Health Services Provided

The Community Experience

CHAs are the relationship bridge to funders, community organizations, local buildings and businesses in which they live.

CHA Survey Snapshot

93% Worked in the neighborhood in which they live

92% Felt they made a positive impact in their community

100% Involved in project design, execution & evaluation

93% The experience has deepened connections with community members

100% The experience has enhanced CHAs personal & professional goals

100% The experience has deepened trust with community organizations

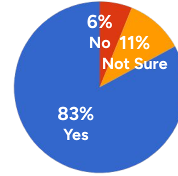
We went into a building in Thorncliffe to do vaccinations… but there was limited engagement. When CHAs joined, we suddenly had a lineup. This amazing level of trust in buildings made a difference in terms of outreach & connections. - MGH Manager

*14/35 CHAs surveyed

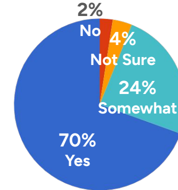
THE CLIENT SNAPSHOT

of Clients surveyed would recommend EEP Supports & Services to a friend or family

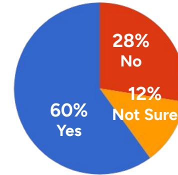
*83 clients surveyed



Did the services [from EE] have a positive impact in moving you towards recovery from the COVID pandemic?



The services I received in the last year have contributed to improving my overall wellbeing.



Were you referred to these services by a CHA?

"The education provided was able to help me build my confidence, I was aware of public health measures and knew how to protect myself." - Client

Top Referral Source (multi-select allowed)

"My experience was wonderful. I only spoke to the person [CHA] over the phone after being referred by the Nurse Practitioner… she was very helpful and very accessible. She was willing to point me into different directions. I really did appreciate that.." - Client

Evaluating the East Effort:

Using a logic model (see addendum) as a framework to guide the evaluation of the East Effort Project enabled us to assess project implementation and measure outcomes against planned goals. Applying a collaborative approach to evaluation, 12 focus group sessions and interviews were completed across 9 different stakeholder groups.

Along with qualitative data gathered from the focus group sessions, we collected and analyzed 3 surveys across 105 participants from CHAs, clients, and Partner Organizations. Combining both qualitative and quantitative data, 3 prevalent themes emerged.

Three Emerging Themes

A ONE TEAM APPROACH

“East Effort is not one organization trying to do everything on their own. They leveraged the network of partners, relying on partners to do what they do best.’ - Community Agency Member

SUSTAINABILITY & SCALABILITY

“The funding [from East Effort] allowed for longer term engagement with our youth and allowed us to focus on sustainability.” - Grassroots Led Group Member

ENHANCING THE CLIENT EXPERIENCE

“Helping people book appointments… Feeling connected to somebody, to be able to ask questions to someone with a similar cultural understanding, this was hugely successful.’ - Community Agency Member

A One Team Approach

It was evident across Partner Organizations that collaboration led to a stronger, unified, and consistent COVID recovery response. Community Partners, CHAs, and Enablers came together, each providing a different set of skills and perspective to quickly understand, plan, and tackle the issues at hand.

Sharing resources, policies, processes, and expertise under a collective vision allowed East Effort to efficiently and swiftly respond with food security programs, check-ins, outreach strategies, and distribute resources and disseminate information.

A COMMON VISION

Having a shared purpose and clear alignment of goals were critical when working cross-functionally and across organizations.

Risk: While the objectives during the pandemic were clear, post-pandemic may not be as straightforward.

Opportunities

- Having 1-2 key focuses is most efficient when working with multiple partners, across the OHT, to build standardization and avoid distractions.
- Communicate and set priorities based on local need.
- Look for commonality between community needs and values to co-create a shared purpose.

COMMUNICATION IS KEY

Open and transparent communication across partners and community members enabled effective coordination, alignment of goals, and shared best practices. Regular website updates of key events and initiatives was flagged as important to share information, and build trust.

Risk: There is risk of reverting back to working in silos post-pandemic.

Opportunities

- Organize regular check-ins, meetings, & brainstorming sessions with Partners & CHAs.
- Continue to dedicate resources (time, staff, space) to joint projects.
- Set up clear platforms & channels for communication and collaboration (Google workspace, Slack, Sharepoint, Trello, etc.).
- Central Platform for updates (e.g. EE Newsletter can be circulated across partners, distributed across web, social, & communication channels).

SHARED LEADERSHIP

Leadership was exemplified in different forms: from the Steering Committee in its ability to make quick decisions, Ontario Health setting KPIs, Ontario Health Team's clear recommendations, to CHAs leading the charge on outreach initiatives with buildings and businesses. A one team approach works best when we know our strengths and weaknesses, and lead based on our areas of expertise.

Risk: Local priorities and health system priorities are no longer in alignment.

Opportunities

- CHAs are trusted members in their community. Continue to train & upskill CHAs to support their neighborhoods, brainstorm outreach & co-create intervention strategies.
- Partners are attuned to the needs of their communities. That sometimes means re-aligning KPIs to fit that need, & vocalizing that need.

Sustainability & Efficiency

One clear benefit of the One Team Approach was efficiency through economies of scale and scope. Pooling resources together allowed for replication of processes, and procedures, and wider audience reach. Leveraging the network of partners meant better brand recognition and access to resources and services (consults with mental health providers, CHAs, volunteers). Consistent local funding permitted programs to mature and evolve over time. Data allowed Partners to act and react to the changing COVID and post-COVD landscape.

STANDARDIZATION

Shared educational sessions, CHA training, and exchange of best practices freed up resources and created cohesion across organizations.
Risk: Having different processes & practices across organizations when working with CHAs can create confusion and disparity.

Opportunities

- Expand group training sessions across Partners & CHAs.
- Foster opportunities to share ideas & best practices.
- Develop guidelines for payment & scheduling across organizations, which may mean nominating a lead agency to oversee CHAs.
- Single source, up-to-date registry of services across Partners to increase referrals.
- Standardize branding to increase visibility (CHA shirts, hats, flyers, tents, etc).
- Move towards uniform reporting practices (record keeping, evaluation techniques, & reporting frequency).

CONSISTENT FUNDING

The process for obtaining EE funding to support local initiatives was highlighted as accessible for both organizations and grass-root led groups, providing opportunities for initiation and expansion of community based programs. The lead agency, being a community based agency with established community connections and partners, is well situated to lead the project.
Risk: Volatile funding makes it difficult to plan & commit to sustainable programs. All stakeholders echoed the need to create a financially stable CHA program to in order to provide consistent support to residents.

Opportunities

- Diversification of funding sources; opportunities for all EE stakeholders to engage in fundraising efforts to support EE initiatives.
- Narrow focus to a few key initiatives to stabilize funding.
- Advocate for CHA programs to be part of base funding.

DATA

Socio-demographic data was used to plan outreach strategies in High Priority Neighborhoods, including addressing language needs. Data was used to prioritize cancer screening and mental health as part of the recovery response.
Risk: Time-lag in data, data accuracy, and data relevance can create distrust.

Opportunities

- Stakeholders identified the need to set priorities informed by data & local priorities.
- Leverage community surveys, focus groups & CHAs to augment government data.
- Promote a QI culture (PDSA cycles, testing) to constantly improve service offerings.
- Understand and track the client experience from referral to engagement, to follow-up.

Enhancing the Client Experience

Collaboration between Community Partners and local CHAs allowed for greater visibility, and reach within the culturally diverse neighborhoods serviced by East Effort. CHAs were the language & cultural bridges into their local communities. Partnerships with local organizations supported clients to address social determinants of health.

LANGUAGE & CULTURAL BRIDGES

CHAs supported residents with language barriers, and assisted EE partners in the planning and delivery of services that are culturally relevant. Residents identified CHAs as their source of trusted connection and relied on them for updates. CHAs helped unearth what 'complexity' looks like today and why structures designed for average populations will not work for equity deserving groups.

Risk: Retention of CHAs from specific ethno-cultural groups and unclear roles can minimize benefits of outreach programs. Formalizing CHA role can discourage skilled applicants on income subsidies from applying.

Opportunities

- Integration of the CHA role as a key stakeholder among EE & OHT partners to co-create and design culturally inclusive interventions.
- Formalize CHA roles through upskilling, job & income security.

VISIBILITY

Visibility of CHAs was most evident in Flemingdon and Thorncliffe Park communities. CHAs were easily identified when leading door-to-door outreach and through services that extended beyond vaccinations. Participants were able to connect with CHAs in their buildings, and information was readily available via Whatsapp groups and flyers.

Risk: In some neighborhoods, CHAs were less 'visible' unless it was specific to a vaccination in the community. Whatsapp was identified as a key platform, but some clients were concerned regarding privacy.

Opportunities

- Centralize & coordinate planning for outreach events in buildings to avoid duplication in services requests made to building management; standardize outreach planning across all 5 neighbourhoods across the EE.
- Trial a new communication platform that does not require phone numbers (e.g. Discord, Telegram, Reddit, Facebook Communities with moderators).

SYSTEM NAVIGATION & PROGRAMS

The COVID recovery response provided connections to services and programs that extended beyond COVID care. Referrals to community programs, such as the Recovery Clinic in Thorncliffe Park, mental health trainings for community residents, food security initiatives, and housing services were identified as supporting residents' needs.

Risk: Primary care attachment and cancer prevention screening were less associated with EE initiatives among Focus Group and Survey participants.

Opportunities

- Continue transition to more in person programming and services.
- Integrate CHAs within interdisciplinary teams to improve system navigation to services addressing social determinants of health.
- Expand scope of CHAs by allowing access to direct bookings for appointments, information on wait-times for services, & complete follow-up on services accessed.

ADDENDUM

LOGIC MODEL

GOALS

- Reduce COVID-19 transmission through community awareness, education, outreach, access to testing centres and enhance recovery
- Increase access to preventative care, primary care, community mental health and addictions services
- Address health inequity, exacerbated by the COVID-19 pandemic, through the provision of wraparound supports

fhc FLEMINGDON HEALTH CENTRE

East Toronto Health Partners

SITUATION

- Newcomers, low-income, and racialized communities have been disproportionately impacted by COVID-19
- Specific supports are needed for low-income communities as they are facing complex barriers to accessing social & health services
- East Toronto has been identified as one of 17 high-needs communities hardest hit by the pandemic
- Flemingdon Health Centre has coordinated the High Priority Communities initiative for East Toronto since 2020

PRIORITIES

- Underserved populations (newcomers, immunocompromised seniors, single parents, large families in need of primary care support)
- High-priority neighbourhoods: Crescent Town/Taylor Massey, Warden Woods, Oakridge, Thorncliffe Park and Flemingdon Park
- Community Ambassadors model development and growth

INPUTS

- Funding through Ontario Health -Toronto Region
- Program proposals from partners and East Toronto Health Partners agencies
- Funding coordination (including with City of Toronto and OHT funds)
- Community Ambassador Structure and Guidelines including lead roles, centralized training and sharing of resources including working with Health Solutions Commons Lab
- East Toronto Health Partners: East End CHC, WoodGreen, TNO, South Riverdale CHC and community leaders
- FHC Stewardship including CEO involvement and logistical supports
- Funded Coordinator Role
- East Effort Steering Committee
- Engaging Community Grassroot Groups

OUTPUTS

- Covid-19 vaccinations, treatment, education and information sharing
- Covid-19 isolation supports: PPE, RAT kits, meal supports, income supports
- Recruitment and training of Community Health Ambassadors in priority neighbourhoods
- Funding approval and distribution to local organizations and grassroot groups
- Development of partnerships
- Support programs for food security
- Support programs focusing on primary health care, prevention and chronic disease management
- Community based programs addressing mental health, isolation supports
- Service Navigation & Referrals

OUTCOMES

PROJECT OUTCOMES

- Hyper-local response targeting a racially diverse population in priority neighborhoods
- Enhance leadership skills and training of CHAs
- Increase awareness and education of community members regarding Covid-19 transmission, prevention and treatment
- Low-barrier access to preventative care through health screening, referrals, and primary care
- Reduce barriers to accessing service via System Navigation Support

COMMUNITY OUTCOMES

- Build community partnerships with healthcare providers to augment trust and improve access to healthcare
- Increase non-traditional partnerships to allow community organizations to have a direct pulse into community needs beyond length of project
- Increase collaboration between organization partners, community grassroots and community leaders
- Enhance primary care, prevention and chronic disease management
- Reduce rates of COVID-19 transmission and enhance recovery

OHT OUTCOMES

- Improved population health by reducing rates of disease, and addressing social determinants of health
- Integrated health services across OHT partners that enhance client experience
- Enhanced referral pathways to community mental health and addiction service supports

Sources & References

Contact Maria (m_calvachi@me.com) or Cinthya (cinthya.narvaez17@gmail.com) for more information.

1. Health KPIs to funder 2022-2023 (Q1, Q2, Q3, Q4)
2. Wraparound support list 2021
3. CHA Survey 2023
4. Client Survey 2023
5. Partner Survey 2023
6. Logic Model Survey 2023
7. Focus Group recordings will be kept for up to 1 year.
   a. FHC Backbone Team
   b. East Effort Steering Committee
   c. Community Organizations Partners
   d. Resident Led Groups
   e. Community Health Ambassador Leads
   f. Community Health Ambassadors
   g. Ontario Health
   h. Ontario Health Team
   i. Clients