



2013-14

London
InterCommunity
Health Centre

Some of our programs, services and partnerships:

Argyle 25 Meals for 25 Dollars
Argyle Community Association
Beats Youth Drop-In
Boyle Activity Council
Cards, Games & Crafts
Chronic Disease Self-Management
Chronic Pain Self-Management
Community Kitchen
Cooking with Kids
Diabetes Clinical
 Management and Education
Diabetes Screening Outreach
Diabetes/Pre-diabetes
 Self-Management groups
Discover Your Possibilities
Dynamic Dozen
Ethno-Racial Youth Mentoring
Float and Glide
Grit Uplifted
Health Outreach for People
 who are Homeless
Hepatitis C Social, Lunch
 and Learn and Dine and Learn
ID Clinics
Immigrant Seniors Drop-In
Immigrant Seniors Home Visiting
Individual, Couple and
 Family Counseling
London Area Network
 of Substance Users
Men's Discussion Group
Mindful Movement

NELCE- North East
 London Community Engagement
North East Community Fair
North East Walking Group
Options – Anonymous HIV Testing
Orion Basketball Camp
Primary Care
Safer Space Drop-In
Seniors' WrapAround
Smoking Cessation
Snacks, Homework,
 Activities & Crafts (SHAC)
STEP Ski Program
Stride and Glide
Summer Jobs for Youth
Tai Chi
Walking School Bus
Women of the World Support
 Groups for Immigrant Women
Yoga for Youth
Youth Community Kitchen
Youth Mental Health Awareness
Youth Tutoring 101

"I cherish this organization and the services
I receive from the doctors, receptionists, nurses
and social workers."

-2013 Client Satisfaction Survey

Board of Directors

We thank the following individuals for lending their talents, time, expertise and passion to the Health Centre by serving on our Board of Directors:

Janet McAllister
CHAIR

Steve Goodine
VICE CHAIR

Mark Denomy
TREASURER AND CHAIR
FINANCE COMMITTEE

Robert Van Praet
SECRETARY AND CHAIR
BOARD DEVELOPMENT
COMMITTEE

Christine Griffith
PAST CHAIR

Vala Gylfadottir
CHAIR, QUALITY OF
CARE COMMITTEE

Bassam Lazar
DIRECTOR

Anne Sawarna
DIRECTOR

Yvette Laforêt-Fliesser
DIRECTOR

Krista Hawrylyshyn
DIRECTOR

Nellie Van Leeuwen
DIRECTOR

Community Advisory Council

The Community Advisory Council reflects the diverse community served by the Health Centre. Members' knowledge, experience and expertise help shape the planning and delivery of our services. Thank you to all members for your committed participation.

Sardar Ahmad
Melissa Anthonyson
Richard Cook
Michael Courey
Maria Forte
Dennis Greason
Asha Mohamed
M. Saeed Mokhtarzada
Rob Newman
Susan Thompson
Kyle Willenbucher



Introduction

Every year the health care sector generates a new buzz word or catch phrase coined by a politician eager to put their stamp on the changes within the sector.

The current catch phrase is “system transformation.” You hear it when people talk about “Health Links” and emergency department diversions. You hear it when people talk about reducing wait times for surgery, or responding to reports of people with mental health issues sleeping in hospital hallways.

As a community health centre (CHC), we have an important role to play in “system transformation.” Included within our annual report you will find a number of ways in which we contribute to providing health care differently.

As with many of Ontario’s CHCs, we work with people who face barriers to accessing care. Our data tells us that these clients are twice as complex as those seen in an average family physician’s practice. Because of their complex physical, mental health and social needs, they access a lot of system resources – a lot of services, and a lot of providers.

So, what are we doing about it? As part of our Quality Improvement Plan, we reviewed the reports that we receive from the hospital about our clients and their use of the local emergency department. Based on what we found, we know we need to provide services differently for clients who very frequently seeking care in the emergency departments (see page 20 for more information).

We are also redesigning the services that we provide for our clients who are homeless and at risk of homelessness. At the end of 2013/2014 we received funding through the Southwest LHIN to takeover the services that were previously offered by a family health team at the Centre of Hope shelter. This new third location primarily serves individuals who are homeless. In a series of facilitated sessions, we are now redesigning how we deliver services to this community to ensure that it best meets their needs. The working group includes seven clients who have lived experience of homelessness, as well as Centre staff. We anticipate unveiling the results of this work in the fall of 2014.

“The mother (mentor) program is wonderful. I appreciated the help and the care from staff. I enjoyed the women of the world program and summer camp for my children.”

~2013 Client Satisfaction Survey

As a CHC, we are not only concerned about the clients who come through our doors, but the broader community as well. Our model of health and well-being includes the guiding principles of working towards health equity and social justice, as well as embedding community vitality and belonging into our programs and services.

This work of “system transformation” often takes place in our community programs and services, where we collaborate with community partners

to raise issues and advocate for social policy change – like increases to the basic income amount for people on Ontario Works, or increasing access to dental services, or lifesaving medications like Naloxone.

Finally, we are committed to being accountable for doing what we say we are going to do and reporting our progress along the way. Two tools used for reporting are our Multi-Sectoral Service Accountability Agreement (M-SAA) from the South West LHIN and the Quality Improvement Plan (QIP) from Health Quality Ontario.

Both of these documents are accessible on our website and share with you – our stakeholders – the targets that we want to achieve and the improvements we hope to make to improve the health care system for our clients and community.

We look forward to continuing the conversation about what will make a difference in your health and in the health of our community.



Janet McAllister
BOARD CHAIR

Michelle Hurtubise
EXECUTIVE DIRECTOR

Our Staff

Full-time, part-time and contract staff employed by the London InterCommunity Health Centre in 2013-2014:

Agyem, Evelyn
Agah Banaei, Nadjla
Alam, Huma
Albarracin, Yamile
Ahmed, Kasif
Alhout, Ahmad
Baigent, Krista
Baldwin, Clark
Beharrell, Laura
Beukeboom, Carolyn
Bodkin, Anne
Bolack, Meaghan
Boyd, Angela
Bradley, Nancy
Campbell, Catharine
Cassidy, Karima
Castellanos, Adriana
Cimo, Adriana
Colenutt, Brianna
Cornwell, Megan
Cresswell, Dayna
Densky, Tosha
Desjardins, Lorraine
Doumkou, Anthoula
Dowsett, Jennifer
Dupon-Martinez, Patricia
Duquette, Cara
Eastabrook, Henry
Em, David
Finigan, Anne
Firth, Tim
Fisher, Cassandra
Frackowiak, Sylwia

Gingerich, Mary
Hanna, Lydia
Happy, Shelly
Harris, Jamie
Harris, Cassandra
Harris, Dawn Marie
Ho, Michael
Hurtubise, Michelle
Huntus, Jesse
Irman, Aatika
Jackson, Sherrill
Kajenthira, Aparna
Keith, Sharon
Kooistra, Diane
Knill, Mandy
Kreiger, Erica
Lacey, Dharshi
Lawal, Ola
Lawrence, Sarah
Licorish, Shand
Malone, Mandy
Malott, Lauren
Manser, Livia
Marion-Bellemare, Eileen
Martyniak, Dawid
McCoskey, Kori
McCulligh, Stephanie
Meathrell, Julie
Miletic, Sarah
Millar, Destini
Miller-Nogueiras, Abby
Msimanga, Melissa
Munro, Maxine
Nash, Greg
Noftle, Brooke
Nuric, Mersija
Nyiranmengimara, Isabelle
O'Connor, Tina
Parra, Clara
Patterson, Sarah

Pemberton, Melissa
Oke, Eva
Pham, Phuoc (Ken)
Pierce, Blair
Pierre-Pitman, Lyn
Pinylo, Jason
Pluchowski, Bogumila
Pollard, Alex
Rana, Gurbir
Rayner, Jennifer
Rice, Sarah
Romilowych, Aja
Roldao, Tanya
Salem, Homa
Sarathy, Ayesha
Sargolzaei, Fatemeh
Schust-Lawrence, Barbara
Sereda, Andrea
Sexton, Elizabeth
Sharpe, Andrew
Sinal, Kendra
Sinasc, Lorrissa
Singh, Navpreet
Skubel, Mary
Smily, Colleen
Tobin, Sue
Topping, Amanda
Town, Ted
Traore, Yacouba
Vanderhorst, Liz
Veldhorst, Joanne
Walsh, Muriel
Watt, Carol
Weaver, Melanie
Wheatley, Keri
Williams, Erin
Wilmot, Lindsay
Zeljovic, Irnes
Zeyl, Leanna



Our Volunteers

It takes more than 200 volunteers to run the programs and services offered by the London InterCommunity Health Centre.

These volunteers bring creativity, talent, enthusiasm and a wealth of knowledge to our work. Volunteers are the eyes and ears of the community – acting as advisors to the organization through the Community Advisory Council and ensuring that our staff are in touch with the communities we serve. They help us connect with isolated men, women and children through Women of the World, the Ethno-racial Youth Mentoring Program and Seniors WrapAround. They meet frail, elderly clients in their own homes to drink tea, share stories, play games and enjoy a laugh or comfortable silence. As we have grown, our volunteers have also helped us with some very practical and tangible tasks: distributing client satisfaction surveys, data entry, sorting clothing donations, making reminder calls to clients, picking up donated food, preparing food for groups and teaching Tai Chi. **To all our volunteers – we couldn't do it without you.**

Our Volunteers

Cekic, Saira
Gazda, Dana
Habumukiza, Antoine
Abdou, Inas
Abdul- Karim, Mohammed
Abiy Bour, Victoria
Aboubakri, Asrin
Adams, Diane
Agudelo, Desiree
Ahmed, Sardar
Alexander, Helena
Alfaro, Susy
Al-Kurdi, Hania
Alsarraj, Nahla
Anderson, Mackenzie
Andrews, Deborah
Anthonyson, Melissa
Assimwe, Deborah
Bailey, Ian
Bamford, Diane
Becerra, Alba Yamile
Belbeck, Brandon
Bigadi, Nasrin
Bindy, Joe
Birnie, William
Blenkhorn, Leah
Brown, Marijke
Campbell, Jane
Campbell, John
Caplan, Daniel
Carlos, Alicia
Carney, Jamie
Cassells, Pearlette
Castro, Martha
Cekic, Saira

Chao, Emily
Chung, Chung Wan
Collins, Denise
Connell, Gloria
Conti, Jon
Cook, Richard
Coulter, Carol
Courey, Michael
Courtemanche, Katie
Crasto, Bernardine
Crasto, Jerome
Dai, Serina
Darnbrough, Donna
Darrell, Mylana
Deboveanu, Vlad
DeGuzman, Chelsea
Delconte, Mark
Demars, Alissa
Denomy, Mark
Devine, Lynn
Diertens-Shaw, Marianne
Dowsett, Sherri
D'Souza, Finola
Duquette, Cara Lynn
El Shamy, Perihan
El-Feghi, Malik
Eqwuonwu, Adaora
Fahmy, Sherine
Feng, Zhi Chao
Fernandez, Joan
Forte, Maria
Fraser, Jacqueline
Furmston, Audrey
Gannavarapu, Lakshmi
Ganshorn, Diana
Gibbs, Laura
Giboire, Dana
Gilbert, Rebecca


Goodine, Steve
Govindaraju, Neethu
Graham, Lorna
Graham, Roy
Graham, Marlene
Grand, David
Greason, Dennis
Greaves, Ann
Griffith, Christine
Guo, Fei Yan
Guzman, Claudia
Gylfadottir, Valgerdur
Halford, Carroll
Hamou, Mudrika
Hawrylyshyn, Krista
Henderson, John
Henderson, Paige
Henderson, Susan
Ho, Lina
Hoffman, Karen
Hu, Emily
Hudie, Wynter
Hussien, Sherin
Innis, Charles
Jabbari, Zahra
Jarquin, Yasika
Johnston, Gordon
Johnston, Teresa
Kanaan, Najla
Kazibuwami, Edgard
Kiewiet, Katharina
Koh, Jane
Kong, Chanine
Kooy, Clyde
Kooy, Henry
Laforêt Fliesser, Yvette
Lannin-Neevel, Mary
Lau, Clarrisa

Lazar, Bassam
Le Claire, Kristina
Lee, Alice
Li, Daniel
Liem, Jenny
Liu, Luca
Luistro-Innis, Carolyn
Mabius, Maria Elena
MacCauley, Christine
MacKaellar, Julie
MacKinnon, Erin
Maclean, Jennefer
Malkani, Niyati
Mallory, Mary Ann
Manser, Livia
Markham, Nicole
Martinez, Anglica
Martinez, Rita
Mashali, Dalia
Maxwell, Judy
Mazhar, Saba
McAllister, Janet
McColl, David
McConnell, Kelly
McGillivray, Kelly
McIntyre, Judy
Meeks, Andrea
Meeks, Anastasia
Menyumurenyi, Larissa
Min, Jina
Mohamed, Asha
Mokhtarzada, Saeed
Monaco, Diana
Mousa, Sabah
Munro, Donna
Nagesvaran, Thy
Naggy, Nancy
Nchendy, Ebele

Newman, Rob
Nicholas, Shyvonn
O'Hagen, Carey
Omar, Mohamed
Ouch, Vanna
Petio, Petio
Pirie, Meg
Platero, Jenny
Pope, Marianne
Quadros, Agatha
Quezada, Jose
Quli, Mohammed
Rajic, Stanislav
Ralhan, Aanchal
Rana, Huma
Revenda, Olivia
Rivas, Daniela
Robinson, Leanne
Rojo Mateus, Angela
Salih, Mohammed
Sawarna, Anne
Scoville, Carline
Scully, Katie
Seale, Paul
Selvathilagan, Kavetha
Senaviratna, Udani
Sexsmith, Robert
Sharma, Srinitya
Shepherd Mohammed, Dominic
Singh, Nav
Solis, Martha
Sollazzo, Christopher
Sollazzo, Jerry
Sollazzo, Lucie
Somasundaram, Janakan
Statler, Julie
Stronghill, Heather
Sullivan, Elizabeth

Taclaboa, Janelyn
Taheri, Zakereh
Teeple, Bailey
Thompson, Susan
Trinder, Mark
U'Ren, Phylis
Van Bavel, Megan
Van Praet, Robert
VanLeeuwen, Nellie
Venneri, Sandra
Villeda, Jose
Walker-Stewart, Susanne
Warnock, Ashley
Weaver, Laura
Weis, Joeseeph
Willenbucher, Kyle
Wilson, Nancy
Wong, Anthony
Woods, Darren
Wright, Julia
Yang, Julia
Zarify, Karima
Zeljko, Irnes
Zeyl, Jim

WE APOLOGIZE FOR ANY ERRORS
OR OMISSIONS TO THIS LIST.



"Volunteers don't necessarily
have the time, but they have the
heart."



Children, Youth and Family Team

Shortly after the 2007 Youth Outreach Worker (YOW) program launch in North East London, community stakeholders from other planning districts began asking when the program would be expanded to include other priority neighbourhoods.

Stakeholders including youth, their families, community leaders and service providers have expressed this desire via service transactions, engagement programming, YOW community consultations and service provision.

Most often, support for Argyle (Marconi – Hilton), East London (Old East Village) and/or Medway (Limberlost – Whitehills) is requested. Assessment by the Health Centre concluded that geographic expansion of the Youth Outreach Worker program to the Argyle and East London neighbourhoods was the next best step.

This decision was partially informed by the realities of family transitions between neighbourhoods due to housing, school boundary overlap, geographic proximity of the current priority areas, and the similar socio-economic characteristics of the districts.

“There should be services for pre-teen to teenagers about mental health.”

–2013 Client Satisfaction Survey

Socio-Economic Characteristics 2010

Argyle & East London		North East London	
Total youth population: One of the highest total number per districts.	6,697	Total youth population: Highest total number per districts.	7,102
Lone parent w/children ≤ 18: Highest total number per districts.	1,580	Lone parent w/children ≤ 18: One of the highest total number per districts.	1,350
Unemployment: Highest total % per district.	9.4%	Unemployment: One of the highest total % per districts.	7.5%
No OGD diploma, certificate or degree: Highest total %.	22.0%	No OGD diploma, certificate or degree: One of highest total %.	20.6%
Average family income (000s): One of the lowest \$ average per districts.	\$56,900	Average family income (000s): One of the lowest \$ average per districts.	\$57,100

With information taken from the 2008 Stats Canada Survey and the 2011/2012 Fraser Institute Report on Education in Ontario.

Concurrently, the community development workers extended their traditional area of service delivery to include the Argyle planning district. The initial focus has been to establish and build relationships with residents in order to address their issues and cultivate a sense of trust. This expansion has promoted stakeholder partnerships and resident engagement as well as an alignment of resources in support of family-centred care. Acting as advocates, enablers and/or mediators, community development workers support clients to increase control over and improve their health outcomes.





Moving Forward with Confidence

It was three years ago when a family friend referred Ashley Thompson to the Health Centre's Youth Outreach Worker team.

She was experiencing significant anxiety and trying to cope with some difficult life events. Youth Outreach Worker, Aparna Kajenthira, was her first contact with the team.

"I was skeptical really. And I found the whole thing nerve-racking," remembers Ashley, who considers herself a private person and had never before shared her story with a social service agency. "Aparna helped me feel comfortable right from the first visit. I had certain ideas about what seeing someone would be like, but it was relaxed and friendly," she remembers.

Ashley had graduated from high school, but didn't think she'd go to college. She was shy and closed off, scared of what would come next in her life. Meeting with a Youth Outreach Worker allowed Ashley to explore her feelings, talk out potential solutions and consider the future.

Together they broke down the issues she faced, discussed possibilities and made plans for moving forward. Ashley applied for and was accepted by the Police Foundations course at Fanshawe College and has recently, at 22, graduated. She reflects on her motivation: "My Dad was in and out of trouble with the law and I knew I wanted to be part of the solution, working on prevention

"It's important to see that people who are successful have experienced hard times and struggle as well."

of problems." She has recently applied for a security job with the Canada Border Services Agency – a process she knows may take up to 18 months. She's undaunted.

"I had never felt proud before. Never thought it was okay to celebrate accomplishments. Now I'm not so shy, I walk with my head up. I'm more confident. People close to me have noticed a huge difference," she says, adding, "I can do anything I put my mind to."

Today Ashley encourages other youth to make a call, even one that feels scary, to seek help with issues like depression or anxiety. "People back away from those terms and try to ignore what is going on. But anxiety impacts every aspect of your life. I didn't want people to judge me for getting help. But it works. I even referred my own sister."





Diabetes Self-Management

In 2013-2014 we continued to emphasize the expansion of our outreach programming.

The team partnered with another community physician, bringing the total of physician outreach sites to five. These partnerships bring additional resources to family physicians and reduce barriers to diabetes care services for individuals living with pre-diabetes. Another partnership involved the Middlesex-London Health Unit and the Western Fair Farmers market. We received \$1,200 in harvest bucks – vegetable and fruit vouchers – for piloting a series of Food Skills nutrition education classes.

Two series of four classes each will be offered to 10 individuals per series. Finally, in addition to running a number of self-management groups (including a new group for the Korean community) and offering one-on-one appointments with our clients, we also participated in a large scale screening event at the London Muslim Mosque. More than 80 individuals were screened on that day.

Hepatitis C Care Team

The Hepatitis C Care team targets those clients who are at risk for hepatitis C, or living with hepatitis C, and specifically those clients who are injecting drugs and have complex health and social needs – including poverty and mental health concerns.

At its initiation, the team consisted of a Nurse Practitioner, Social Worker, Outreach Worker, and Peer Support Worker. We have now added psychiatry services and a Registered Nurse to the team. Services include hepatitis C testing, treatment, education and outreach. We offer groups for meeting others living with hepatitis C, education as well as social opportunities. The team is in its third year of providing hepatitis C care in the London community and we increased the number of clients served by 15% (to 299) over the previous year. We are proud to share that 23 clients have completed the difficult and lengthy treatment process and 8 clients are currently receiving treatment.

Canadian
Breast Cancer
Foundation



Get on board for



Immigrant and Ethno-cultural Communities

In 2013-2014 we re-focused our efforts on health promotion and education – on keeping our seniors healthy, and offering educational opportunities to the newcomer women we serve.

In collaboration with our primary care, mental health and diabetes teams and external community agencies, we offered workshops on mental health, managing your health in Canada, cancer screening and prevention, diabetes self management, exercise and nutrition. Participants in these workshops included: immigrant women in our Women of the World Program, and clients of the Seniors' WrapAround Program and the weekly drop in program. As a result of a new partnership with the Horton Street Seniors Centre, our seniors also have access to exercise programming that is tailored to their needs.

The Health Centre funded three multi-lingual volunteers to become fitness instructors through the Canadian Centre for Activity and Aging. With these volunteers as instructors, and in partnership with the Seniors Centre, more than twenty immigrant seniors now participate in a weekly exercise program.

Five of these seniors have already joined the Seniors Centre as members and are accessing the full range of services. One of our key goals as a team is to facilitate the integration of immigrants into mainstream programs and services within the community by breaking down the barriers to participation.



Mental Health

In September 2013, the Mental Health Team completed the legal process necessary to become a Smoking Treatment for Ontario Patients (STOP) program site.

STOP is a province-wide joint initiative of the Ontario Ministry of Health and Long Term Care – Health Promotions and the Centre for Addiction and Mental Health. This initiative delivers smoking cessation treatment and counseling to eligible Ontario smokers who wish to quit.

Our collaboration with the Centre's Primary Care Team resulted in the first Medical Directive in the history of the organization. The Medical Directive allows certified allied health providers to dispense Nicotine Replacement Therapy (NRT) to registered clients. NRT comes in the form of nicotine patches, lozenges, gum and inhalers at no cost to the client.

Chronic illness is one of the top reasons why people seek our services. To adequately meet client needs we often make several referrals to internal specialty teams. The unintended consequence? The client was subjected to many different assessment interviews – causing him or her to tell their story repeatedly.

Based on client and staff feedback, we reassessed our client intake services and reorganized our resources. We now have a dyad consisting of a Systems Navigator and the new position of Assessment Coordinator.

This new dyad completes a health assessment for each client which is then tailored for the specialty teams – eliminating the need for subsequent intakes/assessments. The goal is that once this health assessment is completed the client is immediately ready for program/services.



Poverty, Homelessness and Options

In addition to increasing access to primary care and social services for people who are homeless or at risk of homelessness through the addition of a Wellington Street site, the Poverty, Homelessness and Options Team had a productive year of partnership development and ensuring the voice of those with lived experience was heard and valued.

In collaboration with internal and external partners we:

- Led and supported London's first International Overdose Awareness Day in August, attended by 150 people
- Created Ontario's first multi-partner community naloxone distribution program to train and equip illegal drug users to save the lives of their peers
- Selected, supported and brought our clients to the planning table as expert consultants to our emerging conceptual model of health care delivery for those who are homeless
- Had significant successes with the Options Clinic's anonymous testing outreach to local First Nations communities

- Continued to enhance and grow our safer space strategy in the Health Outreach drop-in area, reducing behavioural concerns and engaging clients visiting the health outreach differently

We look forward to The Naloxone Program launch, progressive successes in our Safer Space strategy and encouraging the voices and experiences of our clients to be heard and valued.



Primary Care

This year, the Primary Care team saw its most significant growth with the Health Centre's integration of the former Centre of Hope Family Health Team.

Our months were filled with planning, hiring additional clinical staff, and preparing to bring the Family Health Team's clients into our care. We are very pleased to have the Wellington Street site up and running and to be providing services to more clients in the community.

There was also a lot of focus on our Quality Improvement Plan this year, especially in the area of chronic disease management. In particular, we identified the need to focus on chronic obstructive pulmonary disease (COPD) services, as a very high percentage of our clients have been diagnosed or are at risk. We had also received feedback that our clients were continuing to face barriers to accessing COPD services elsewhere in the system. Two clinical staff have taken the Respiratory Educator Program and are pursuing partnerships with the Primary Care Asthma Program at St. Joseph's Health Care London. In 2014-2015, we are looking at ways to improve COPD services available at our Health Centre.

We continue to explore creative partnerships with other community agencies, especially where there are gaps in services for particular populations or disease processes. This year we increased partnership with the Cross Cultural Learners Centre and community family physicians to provide initial screening and recommended testing for communicable diseases, and to address health care issues identified in refugee camps. These partnerships will continue to evolve in the year ahead.

Primary Care Administration

In addition to new coworkers, a new electronic medical record (Nightingale on Demand) and a third site for which to develop new processes and procedures, the Primary Care Administration Team implemented same day appointments.

This has increased the access to health care for clients experiencing acute problems. The majority of same day or next day appointments available were filled.

Also new this year was as partnership with Fanshawe College Dental Hygiene to run an eight week program from the Dundas Street location. 20 clients received thorough dental exams, education on oral health and referrals to community dentists. One client was referred to and accepted by a dentist for a full mouth extraction and dentures that were covered by ODSP.

Finally, we worked toward building capacity within our team by cross training six medical secretaries to work at our Huron Street location and six medical secretaries to work at our Wellington Street location. We can now provide better, more consistent and more knowledgeable coverage in the instances of illness or vacation absences.



Nightingale on Demand – A New Electronic Medical Record

Although some CHCs have used paper medical records since their inception, our Health Centre has used an electronic medical record, Purkinje, since 2006.

In 2012-2013, the Association of Ontario Health Centres, lead by the provincial Information Management Committee, signed a contract with Nightingale Infomatrix Corporation that would see its bilingual, web-based Nightingale on Demand EMR implemented at every CHC across the province. Our Health Centre “went live” with NOD on November 28, 2013.

This new EMR reflects a sector-wide approach to information management strategy and gives CHCs the ability to communicate electronically with the rest of the health care system including SPIRE and OLIS. Fourteen staff were trained as NOD Super Users and 75 staff were trained on the new system.

NODSENSE
SOCIETY



281 Wellington St.

**On Friday March 7, 2014,
the health and social services
provided by the Centre of Hope
Family Health Team were
transitioned to the
Health Centre.**

This change in responsibility was mandated by the Ontario Ministry of Health and Long-Term Care through a funding agreement with the South West Local Health Integration Network. No funding was lost as a result of the change and the end result has been more funds directed to front line support for clients rather than to administrative services.

The care of approximately 1,500 clients was impacted by the transition. As part of our agreement with the SW LHIN, the Health Centre committed to ensuring that all of these clients – many homeless or at risk of homelessness – would continue to receive quality primary health care services. Fourteen staff were hired to operate the site and deserve the organization's recognition for efficiently completing hundreds of new client intakes and comprehensive assessments to ensure the continuity of quality care for clients with complex needs.



A closer look at six frequent users of the emergency department.

- 6 clients went to the ED 137 times over three months.
- 2 of the 6 went a total of 111 times.
- These 6 clients ALSO visited the Health Centre 62 times over the same time period.
- 2 clients are women, 4 are male.
- 3 clients are seen in the Dundas Main Clinic; 3 in the Health Outreach Program.
- All are over age 45.
- 5 have addiction issues and 3 have mental health issues.

Quality Improvement – Emergency Department Diversion

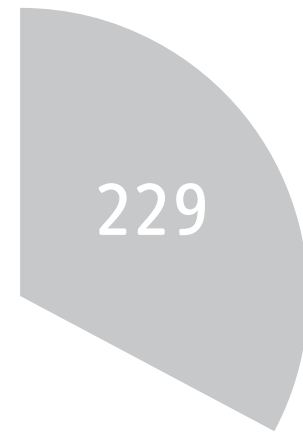
As a CHC, we commit to working effectively with a variety of health system partners, ensuring our clients get the best care and we all make the best use of health system resources.

One of those partners is the hospital emergency department. We believe our clients' non-emergency needs are best served by their primary care providers – not the busy emergency department. Yet, we know that a number of our clients visit the emergency department very frequently. But how often is frequently? And why do they go there? Our data told an interesting story. Below is a snapshot of our data from July-September 2013.

- 229 clients out of 3171 primary care clients went to the ED 474 times.
- 49 of these clients had issues that resulted in an admission to the hospital.
- 53% of these visits took place during the daytime – when they could have been seen by us.

As part of our Quality Improvement Plan for the upcoming year, we will work closely with these frequent visitors to the emergency department to see if we can serve them differently. Our quality improvement goal is to reduce our total number of ED visits by half over the course of a year. By focusing on the highest of our users we hope to effect this change in a way that is best for clients and best for the system.

A LeNS (London Hospitals Electronic Notification System) Report is a report that notifies a physician via internet that their client has accessed a hospital and for what reason. During quarter one of this year, we worked with the IT department at LHSC to develop a monthly summary of the LeNS reports that each physician could download from the website. Therefore, we now have the ability to aggregate the data.



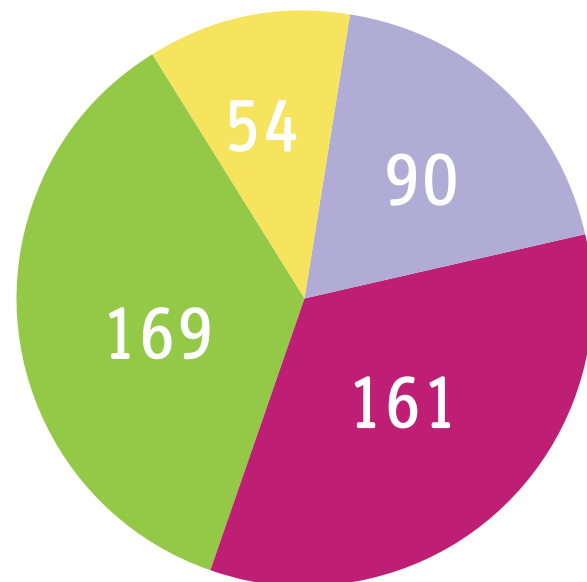
ER Visits

- Number of Clients
- Number of ER Visits

*49 clients were admitted to hospital as a result of their ER visit Subsequently, 2 clients died.

When we look at our LeNS reports for Quarter 2 (July, August, Sept.), we can see that 229 clients accessed the Emergency Department 474 times. 49 of those clients had issues that resulted in admission to the hospital.

Surprisingly, the majority of these visits did not take place during the evening hours and overnight. 53% of the visits took place during the daytime between 6:00am and 5:00pm.

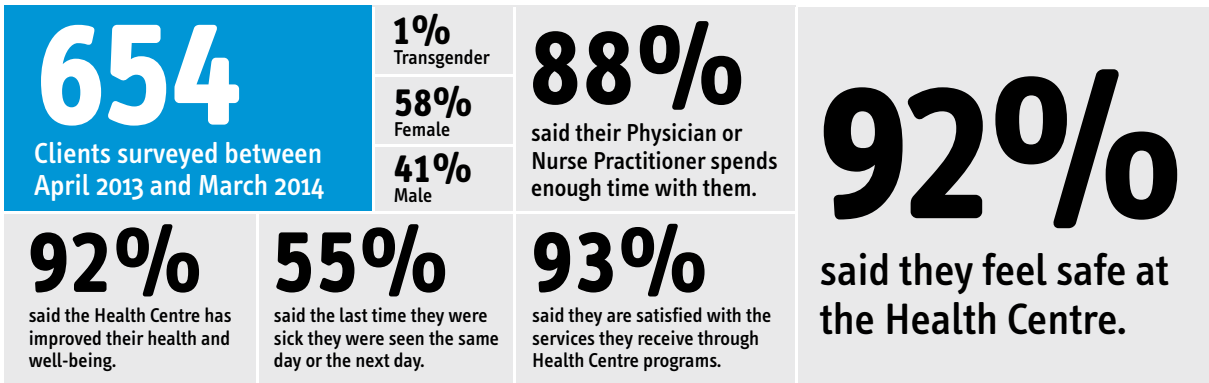


When do ER visits Happen?

- 6am - 12pm
- 12pm - 5pm
- 5pm - Midnight
- Midnight - 6am

Client Satisfaction 2013-14

This year, the Health Centre changed its client survey process to gain a better sense of client perspectives and needs over a period of time. Rather than collecting surveys for only two weeks in March, we’ve been actively seeking client feedback over the entire year. Here are some highlights:



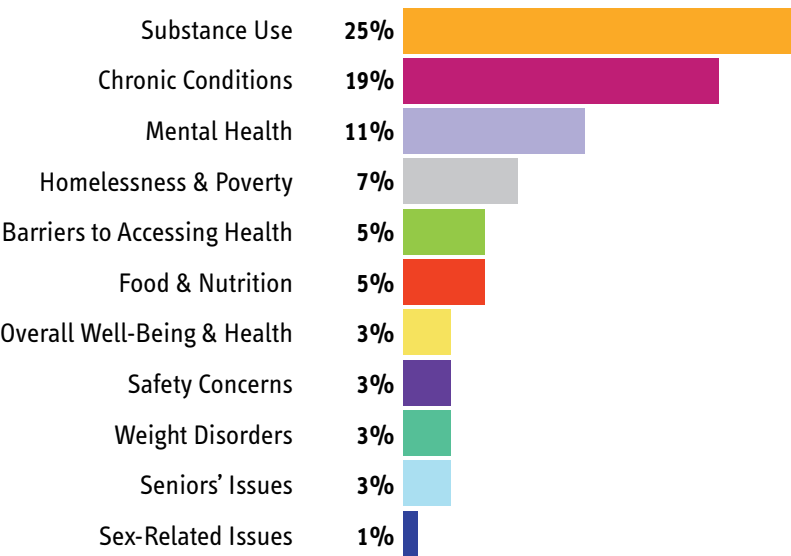
Clients said the Health Centre could improve by offering more programs, hiring more staff, enhancing reception support, moving to a new building, or expanding hours. 12% of respondents would like more opportunities to participate in the planning of programs they need.

Clients reported that the best part of the Health Centre is our friendly, understanding and non-judgmental staff (44%). Other responses included the information, activities and support clients receive in our community programs; the special care, attention and approach they receive in health care services; and our impact in the larger community.

“Relationships, connections and community are good for our health.”

-2013 Client Satisfaction Survey

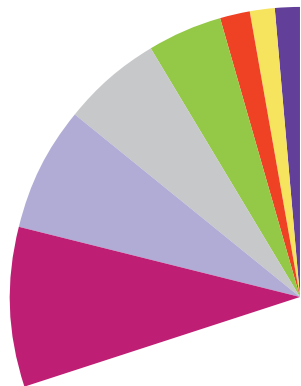
What is the most important Health Issue in our community?



Financials

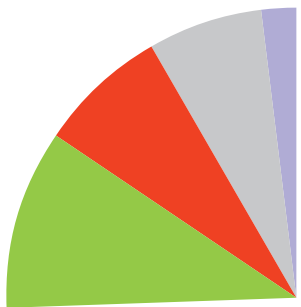
Funding Resources

	PER CENT OF BUDGET
SW LHIN – Community Health Centre	70
SW LHIN – Aging at Home Program	8.9
MOHLTC – Diabetes Strategy	7.1
MOHLTC – Hep C Program	5.6
MCYS – Youth Outreach Program	4.1
Other Income	1.6
MOHLTC – HIV/AIDS Program	1.5
United Way – Women of the World	1.2



Expenses

	PER CENT OF BUDGET
Wages & Benefits	74.5
Administrative Costs	10.2
Program Costs	7.1
Occupancy Costs	6.3
Amortization of Capital	1.9



SW LHIN – South West Local Health Integration Network
 MOHLTC – Ministry of Health and Long Term Care
 MCYS – Ministry of Children and Youth Services

For a copy of our complete audited financial statements, please contact 519-660-0874 and ask to speak to the Finance Manager.



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