2018 UPDATE
211 Continues to Expand in Canada

72% or 26 million Canadians

91% or 283 million Americans

www.211.ca
211 Ontario System – Community Up Model

**Ontario 211 Services** is the provincial transfer payment agency for the Ontario Ministry of Community and Social Services, and it provides oversight and coordination for the Ontario system.

Six **Regional Organizations** provide integrated service delivery to all of Ontario.

Central East Region is served by **Community Connection in Collingwood**.
<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Households</th>
<th>Total Contacts</th>
<th>Pop % Rate</th>
<th>Households % Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grey</td>
<td>93,830</td>
<td>39,563</td>
<td>4,753</td>
<td>5.1%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Simcoe</td>
<td>479,650</td>
<td>183,536</td>
<td>15,516</td>
<td>3.2%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Bruce</td>
<td>68,147</td>
<td>28,866</td>
<td>1,558</td>
<td>2.3%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Muskoka</td>
<td>60,599</td>
<td>25,431</td>
<td>1,010</td>
<td>1.7%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Peterborough</td>
<td>138,236</td>
<td>57,743</td>
<td>1,276</td>
<td>0.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Perth</td>
<td>75,122</td>
<td>29,400</td>
<td>618</td>
<td>0.8%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Dufferin</td>
<td>61,735</td>
<td>21,918</td>
<td>424</td>
<td>0.7%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Northumberland</td>
<td>85,598</td>
<td>35,686</td>
<td>659</td>
<td>0.8%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Huron</td>
<td>59,297</td>
<td>24,194</td>
<td>437</td>
<td>0.7%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Parry Sound</td>
<td>42,824</td>
<td>18,679</td>
<td>289</td>
<td>0.7%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Kawartha Lakes</td>
<td>75,423</td>
<td>31,106</td>
<td>447</td>
<td>0.6%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Haliburton</td>
<td>18,062</td>
<td>8,443</td>
<td>118</td>
<td>0.7%</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>2016 Central East Census Data</strong></td>
<td><strong>1,164,693</strong></td>
<td><strong>465,002</strong></td>
<td><strong>27,105</strong></td>
<td><strong>2.3%</strong></td>
<td><strong>5.8%</strong></td>
</tr>
</tbody>
</table>
2017 Central East Response Rate & More

Average Wait in Queue (seconds) | Average Talk Time (minutes)
--- | ---
50 | 4.47

Abandonment Rate | Average Seconds to Abandonment
--- | ---
7% | 68

Abandonment Time Breakdown
- Less than 15 seconds: 0.3%
- 15 to 30 seconds: 2.7%
- 30 to 60 seconds: 25.2%
- 60 to 120 seconds: 45.1%
- 120 to 300 seconds: 20.5%
- Greater than 300 seconds: 6.2%

Total Contacts: 29,720
- (119 avg per work day)
- (572 avg per week)
- (2,477 avg per month)

Contact Centre Hours/Calls
- After Hours (7 pm-7 am Weekdays, Weekends, Stat Holidays)
- Regular Business Hours M-F 7:00 am-7 pm

Contact Centre Hours/Calls:
- 79%
- 21%
Grey County 2017 Caller Needs

#1 Utility Assistance 15.2%
#2 Housing 13.5%
#3 Health 10.1%
#4 Government Services 8.5%
#5 Legal/Public Safety 6.7%
#6 Income/Financial Assistance 6.3%
#7 Education 5.9%
#8 Community Services 5.3%
#9 Individual/Family Services 5.1%
#10 Mental Health/Addiction 4.6%
Grey County
2017 Unmet Needs

Health 32 (half were dental)
Housing 23 (most were shelters)
Utility Assistance 11 (most were financial)
Community Services 11
Income Support/Financial 10 (most were rent assistance)
Food/Meals 10 (most were home delivered meals)
Mental Health/Addictions 9 (access issues - hours & transportation)
Individual/Family Services 7
Transportation 7
Education 5
Volunteers/Donations 5
Consumer Services 3
Government 3
Legal/Public Safety 2
Arts, Culture & Recreation 1
Information Services 1
211 Central East Integrated Database
Grey and Bruce Resources

<table>
<thead>
<tr>
<th></th>
<th>Grey</th>
<th>Bruce</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agencies</td>
<td>438</td>
<td>274</td>
<td>712</td>
</tr>
<tr>
<td>Sites</td>
<td>561</td>
<td>411</td>
<td>972</td>
</tr>
<tr>
<td>Programs</td>
<td>662</td>
<td>464</td>
<td>1,126</td>
</tr>
<tr>
<td>Services</td>
<td>1,796</td>
<td>1,216</td>
<td>3,012</td>
</tr>
</tbody>
</table>

**Ontario:** 30,591 agencies; 45,973 sites; 60,003 programs; 149,468 services
Central East Database – organic search example:
2017 Online Access to Community Resources

Total Sessions
211CentralEastOntario.ca: 1,295,519
(includes all websites, online directories and Google searches with database listing results)

21% over 2016

Traffic Sources:

- **1,158,519** Organic
- **83,348** Direct
- **50,549** Referral
- **3,103** Other

User Devices:

- **51%** Desktop
- **39%** Mobile
- **10%** Tablet

Note: A session is a group of user interactions with a website within a given time frame. Organic traffic comes from search engines. Direct traffic comes from typing a specific URL. Referral traffic comes from other URLs.
211’s emerging role in bridging the gap between primary care & community, social, government services
211 & the Social Determinates of Health

WHAT MAKES CANADIANS SICK?

50% YOUR LIFE
- INCOME
- EARLY CHILDHOOD DEVELOPMENT
- DISABILITY
- EDUCATION
- SOCIAL EXCLUSION
- SOCIAL SAFETY NET
- GENDER
- EMPLOYMENT/WORKING CONDITIONS
- RACE
- ABORIGINAL STATUS
- SAFE AND NUTRITIONAL FOOD
- HOUSING/HOMELESSNESS
- COMMUNITY BELONGING

25% YOUR HEALTH CARE
- ACCESS TO HEALTH CARE
- HEALTH CARE SYSTEM
- WAIT TIMES

15% YOUR BIOLOGY
- BIOLOGY
- GENETICS

10% YOUR ENVIRONMENT
- AIR QUALITY
- CIVIC INFRASTRUCTURE

These are Canada's Social Determinants of Health #SDOH

CMA infographic, based on: Canadian institute for advanced research – Estimated impact of DOH on population health status
Equitable Access to Services

Equity doesn’t mean equality.
Community Navigation

Patient Example, referral from primary care:

- Male, age 79, leg amputation due to diabetes complications, needed $4,576 for a leg prosthesis
- Community Navigator contacted the patient, completed an income assessment to help determine options
- Patient was referred to:
  - Assistive Device Program ($2,796 confirmed)
  - War Amps ($1,000 confirmed)
- Community Navigator contacted two charities, wrote/delivered support letters, and the patient received a final combined contribution of $780
Primary Care Interventions in Poverty

• 20% of Ontarians live in low income and the health inequities experienced by this population are evident

• Social determinants of health play in increasing risk for the development of chronic diseases

• Low income, in particular, is known to increase the risk of chronic disease incidence and mortality

• Poverty is now seen as a key modifiable risk factor, to be assessed and supported in health care settings
Poverty: A Clinical Tool for Primary Care Providers (ON)

1. Screen Everyone
   “Do you ever have difficulty making ends meet at the end of the month?”
   (Sensitivity now, specificity now for living below the poverty line)

2. Poverty is a Risk Factor
   Consider:
   - New immigrants, women, indigenous peoples, and LGBTQ+ are among the highest risk groups.
   - Example 1: If an otherwise healthy 35-year-old comes to your office, without risk factors for diabetes other than living in poverty, you consider ordering a screening test for diabetes.
   - Example 2: If the otherwise healthy patient who lives in poverty presents with chest pain, this elevates the pre-test probability of a cardiac source and helps determine how aggressive you are in ordering investigations.

3. Intervene
   Ask Everyone: “Have you filled out and sent in your tax forms?”
   - Ask questions to find out more about your patient—employment, living situation, social supports, and the benefits they receive. Tax returns are required to access many income security benefits, e.g., GST/HST credits, child benefits, etc., and property tax credits. Connect your patients to Free Community Tax Clinics.
   - Even people without a regular status may be eligible.
   - Drug Coverage: Use current tax filing to access Trilliums plan for those without Ontario Drug Benefits. Visit drugspencecan.ca for more options.

Intervening can have a profound impact on your patients’ health

Patient Group | Ask | Educate | Intervene & Connect
---|---|---|---
Seniors | Do you have any medication? | Diabetes | Start with Canada Benefits to identify and access income supports for patients and families. Use this in your office with patients and provide with the link.
Families with Children | Do you receive the Canada Child Benefit on the 20th of every month? | Chronic Disease | Intersocial Services can be obtained by applying for Canada Child Benefit when monthly tax return. Eligible families can receive up to $600/year for each eligible child aged 0-16. Families may be eligible for additional benefits through various provincial programs. Eligible families can receive $500/month.
Indigenous peoples enrolled under the Indian Act or recognized by the Indian and Northern Affairs Canada organization may qualify for local, national, or other benefits.
Social Assistance recipients | Have you applied for extra income supplements? | Breast Cancer | Additional benefits available include transportation, medical supplies, special diet, employment supports, etc. A client of the Breast Cancer Foundation of Canada can provide information and assistance.
People with Disabilities | Do you require payment for disability? | Cancer | Major disability programs available (ODS, Disability, Disability Tax Credit (DTC), Veterans Benefits, WCB, Employment Long-Term Protection. Registered Disability Savings Plan (RDSP). Can provide up to 30% tax savings plus interest payments, and is required to receive other benefits including the RESP, which provides up to $20,000 in grants.

Key Resources
- Canada Benefits (www.canadiabenefits.gc.ca)
- 2-1-1 (211canada.ca)
- Your Local Health (www.yourlegalsites.org.ca)

Remember: As health providers, it is our responsibility to provide complete and detailed information about how poverty impacts health and disability.
Working with Family Health Teams
211 Referral Form

• Nine-month pilot with the Georgian Bay Family Health Team (Collingwood)

• How it works:
  1. Fax the patient referral form to 211 if your patient is struggling to make ends meet, is behind on filing taxes, or would benefit from other assistance
  2. 211 contacts the patient, assesses their needs, provides advocacy, information, referrals and assistance to connect them to needed services
  3. 211 faxes a report on the outcomes of the referral

• Outcomes - 49 referrals with 22 patients receiving more services

• Now expanding to Couchiching Family Health Team (Orillia)
Simcoe County Community Paramedicine
211 Referral Form

• One-year pilot with Community Paramedicine

• How it works:
  1. Following 911 response, fax patient referral form to 211 with identified potential needs
  2. 211 contacts the patient, assesses their needs, provides advocacy, information, referrals and assistance to connect them to needed services
  3. 211 reports outcomes for each patient on a weekly basis

• 753 referrals (average of 62 per month)

• Outcomes - 194 patients (26%) received enhanced services

Referral Examples:

Relevant Diagnosis for Referral:
Caregiver Support / Burnout, Cognitive Impairment, Failing Activities of Daily
Comments:
daughter had planned to move parents to Atlanta and care for them, while house for sale/escrow, daughter was caring for them in hotel. daughter has since become overwhelmed - father falls/ca/pneumonia

Relevant Diagnosis for Referral:
Falls
Comments:
pt's wife is primary caregiver of pt. he does attend vons day services that she drives him to 2x per week however with his increase in weakness and likely hood of falls paired with his confusion/dementia he is unable to be left alone so she can attend meetings or provide basic needs. she is open to more assistance in the home.

Relevant Diagnosis for Referral:
Alcohol/Substance Misuse, Caregiver Support / Burnout, Cognitive Impairment, System Navigation
Comments:
pt is spouse of husband with alcohol misuse issues and dementia. She has copd on home o2. no family support around. difficulty managing husband requires help.
Questions?

Slide deck prepared by:
Pamela Hillier, Executive Director
Community Connection/211 Central East
phillier@communityconnection.ca