PROGRAM FILE INDEX

1. Healthy Living Levels and Workplan

BRONZE level HEALTH PROMOTION (Motivation Level 1 on the PAM scale) Access

- Short Term: St. James Town residents will have access to health promotion information, social media contact, screening, local resources and support to improve their overall health

SILVER Level PARTICIPATION (Motivation level 2 and 3 on the PAM scale) Knowledge:

- Medium Term: St. James Town residents will demonstrate knowledge of risk factors for poor health and have started to take steps to address their health through CMT program registration and participation

1. Support: Medium Term: St. James Town residents will perceive that there is screening and supportive follow up within the community to address the risk factor of poor health. Community Assistants support them in their effort to be screened, attend programs and develop social networks

GOLD level HEALTH PLANNING and PARTICIPATION OVER TIME (Motivation level 4 on the PAM scale)

2. Long Term: St. James Town residents will consistently demonstrate good health habits to mitigate the risk of poor health habits. They are learning about behaviour change and how to maintain good health practices over time

2. Program Plan
    a. Monthly Bench Mark Report
    b. Work Plan
3. Health Promotion-BRONZE
    a. Summary
    b. Survey
    c. Program and Services
4. Program Delivery-SILVER
    a. Screening Questionnaire
    b. Pre and Post Skills Checklist
    c. Program curriculum
5. Individual Follow up and support-GOLD!
    a. Health Planner Data
    b. Motivational Scale Data
6. Templates and Examples

1. **Community Matters Toronto**

Program Plan: Dental Screening

Background/Context, Description of Situation: Community Matters is currently providing information and prevention programs to St. James Town residents who are at risk of diabetes, cancer and cardio vascular disease under its Healthy Living in St. James Town initiative. These programs include culturally appropriate screening in a community context. This document proposes to add the issue of oral health to the project providing similar approaches and information to those at risk.

Best Research

Relevant Article	Findings	Implications for Program (good evaluation, design etc)

Program Objective/Hypothosis: To provide basic dental screening and follow up support for residents of St. James Town community.

Target Population: Residents of St. James Town

Program description: A series of educational information and education workshops and screenings provided in a variety of locations by International Educated Dentists and other local Community Assistants. The program will provide oral health information including access to affordable local oral health care and a variety of supports including, where necessary accompaniment.

Program Outcomes:

Access

3. Short Term: St. James Town residents will have access to dental screening and local resources and support to improve their oral health

Knowledge:

4. Medium Term: St. James Town residents will demonstrate knowledge of the risk factor for poor oral health

Support:

5. Medium Term: St. James Town residents will perceive that there is dental screening and supportive follow up within the community to address the risk factor of poor oral health

Participation:

6. Long Term: St. James Town residents will consistently demonstrate good oral health habits to mitigate the risk of poor oral health.

Program Outputs:

1. A Foreign Trained dental professional from the St. James Town community will provide weekly screening clinics for the community
2. A culturally appropriate dental screening process will be established
3. A list of current affordable, culturally appropriate resources will be created and maintained
4. A variety of media will be used to develop Oral Health messages for the community
5. A system of routine follow up for each person screened will be developed and implemented
6. Evaluation Report

Potential Program Partners:

1. Cancer Care Ontario
2. George Brown College
3. University of Toronto
4. Regent Park Health Centre

Annual Program Metrics:

1.	Number of Foreign Trained Dentists who lead the project	2
2.	Number of screening clinics provided	40
3.	Number of residents screened each year	300
4.	Minimum number of media message tools developed annually	4
5.	Number of residents who demonstrate knowledge of the risk factors to oral health	300
6.	Number of residents will perceive that there is dental screening and supportive follow up within the community to address the risk factor of poor oral health	300
7.	Number of residents reached with oral health dental messages	12000

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1. **Work Plan:** **Program: _____** **Community Assistant: _____**

Benchmark	Item	Person	Date
New HP participants (Silver) / month			
Program Specific Bench marks			
Example for Binita: Health Bus Cervical Cancer visits/yr.			
Screenings			
Screening on Bus			
Screening Direct to family Dr			
Mammograms per year			
CanRisk Assessments (Diabetes/ H&S /year			

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HEALTHY LIVING BENCHMARKS 2016/2017 Community Assistant: _____

Description	Responsible			Base	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Health Promotion: Table/Events	All															
Health Promotion: Reach (Bronze)	All															
Add 210 to HP List	Hanan			450												
New HP participants (Silver) / month	All			40												
Health Bus Cervical Cancer visits/yr.	Binita (Said, Aicha)			3												
Screenings	Binita (Said, Aicha)			26												
Screening on Bus	Binita (Said, Aicha)			78												
Screening Direct to family Dr	Binita (Said, Aicha)			100												
Mammograms per year	Binita (Said, Aicha)			60												
CanRisk Assessments (Diabetes/ H&S /year	Binita (Said, Aicha)			150												
FB post per week	Bhavana			3												
FB Reach	Bhavana															
HL Library Additions	Bhavana															
Program attendance		pre	post													
Women's Spa	Binita			9												
Diabetes Management	Surabhi			12												
Stress Management	Surabhi			8												
Life Through Art	Bhavana			8												
Meditation	Surabhi			10												
Yoga	Surabhi			20												
Bollywood	Bhavana			14												
Adults Plus Social	Binita			30												
Adults Plus new Sr Volunteers	Bhavana			4												
Adults Plus Isolated support	Aisha			30												
Adults Plus tel. support	Bhavana			60												
Nutrition	Surabhi			15												
Family Health	Surabhi			15												
Belly Dancing				14												
Men's Volleyball	Said			20												
Zumba				14												
Walking/Stair Climbing	Surabhi			15												
Dental Screening sessions	Usha/ Sofia			24												
Dental Work Shops				50												
FoodShare Sales per visit	Hanan															
Swimming Kids per session	Yasotha			45												
Swimming Adults per session	Yasotha			20												

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Healthy Living Program Benchmarks

		Self Help						Nutrition			Exercise			
		Spa	Life Through Art	Stress Management	Heart and Stroke	Seniors Connections	Meditation	Nutrition	FH	Food Choices	Swimming	Yoga	Walking/Stair	Bollywood Belly/Zumba
Evidence of Community Need														
Best Research/Hypothesis														
Target Group														
Workplan														
Program Description/Flyer														
Staffing-skills,volunteers														
Curriculum														
Use of Media														
Evaluation: pre and post														
Partners														
Database and reporting														

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2. Health Promotion Event Summary

Location:	Date:	Time: From:		To:	
Community Assistant			Follow up completed		
Name		Contact Information		Program Interests	May We Contact You ?
	Email	Address (Apt?)	Phone		

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Community Matters Toronto **Health Promotion Event Summary**

Target Population and Projected Number		
Activities Used	Vendors _____ St JT Arts _____ Screening: Dental ____ Blood Pressure _____ Other Health Demonstration/event _____Beautician/Massage _____ Healthy Food _____ Other_____ Neighbourhood Information: (e.g. Pest Control, Apartment Safety, Benefits Plan,Other)_____	
Number who received health/community information		
Number screened		
Number of registrations for CMT programs		
Flyer Subject	# at Beginning	# distributed by the End
Nutrition		
Swimming		
Health bus		
CMT Flyer		
Residents Comments		
What Worked		
What Didn't Work		
Recommendations		

3. Silver: Programs

COMMUNITY MATTERS TORONTO Winter 2017 PROGRAMS AND SERVICES		
EXERCISE		
SWIMMING (affordable fees) **Lessons** **Family Swim**	Thurs: **Children** -5 -7:30 PM Saturday: **Aquafit**-12-1PM, Thursday 7:30-9PM Sat 1PM - 4PM	Jarvis Collegiate 495 Jarvis Street
NEW! ACTIVE FAMILIES parents and children kindergarten to grade two Jan 15 – Mar 5th **NEW! FAMILIES' DANCE** Jan 15th – March 5th ***NEW! FAMILY OUTINGS SKATING (lessons)***	Sunday 1-2:30PM Sunday 2:30 to 3:30PM Monthly Sunday 2-4PM	109, 240 Wellesley St E 109,240 Wellesley St E Call 416-944-9697 for information.
YOGA	Sat 10 AM – 11 AM Friday 11AM – 12PM	109, 240 Wellesley St E Wellesley Community Centre
NEW! ADULTS' VOLLEYBALL	Monday 6-8PM	Rose Avenue Public School
BELLY DANCING	Saturday 12 to 1:00PM	109,240 Wellesley St E
ZUMBA	Saturday 11AM to 12:00PM	109,240 Wellesley St E
BOLLYWOOD DANCE	Tuesday 6:30PM to 7:30PM	109,240 Wellesley St E
STAIR CLIMBING	Tues 11:45AM and 1:15PM Thurs 2PM	102, 260 Wellesley St E 109, 240 Wellesley ST E
SELF HELP		
HEALTH CHECK IN (weight, blood pressure, blood sugar, dental)	Thurs 10:00AM to 12:00PM	109,240 Wellesley St E
DIABETES MANAGEMENT(For Adults) **NEW! HEART and STROKE GROUP**	Thurs 10:00AM -12:00PM Thurs 4-6PM	109,240 Wellesley St E 109,240 Wellesley St E
MEDITATION	Tues 4:30PM to 5:30PM	109, 240 Wellesley St E

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SELF HELP (continued)		
LIFE THROUGH ART-SELF HELP GROUP	Friday 1:00 to 3:00PM	102,260 Wellesley St E
STRESS MANAGEMENT	Wed 2-3:30PM	109,240 Wellesley St E
WOMEN'S SPA – Health and Beauty	Tuesday 1:00 to 3:00PM	109,240 Wellesley St E
ADULTS +		
SENIORS' CONNECTIONS	Monday 10AM-11:30AM, Thursday 1PM - 3PM	109, 240 Wellesley St E
Adults + HOME and COMMUNITY SUPPORT **Home Management** (affordable fee)	Ongoing Cleaning for older adults	109, 240 Wellesley St E
NUTRITION		
GARDEN WORKSHOPS	**Jan** Dried Herbs and Tea **Feb** Growing Sprouts **March** Herb planting - propagation with roots and cuttings	109, 240 Wellesley St E
FOOD MARKET -fresh and affordable!	Mondays 4:30 to 6:15PM	109,240 Wellesley St E
ADULT NUTRITION	Wed 10:00AM to 12:00PM	109,240 Wellesley St E
FOOD HANDLING	Thurs10:00AM to 12:00PM	109,240 Wellesley St E
NEW! CHOOSE HEALTHY FOODS Jan 11-Feb 8th	Monday 2 PM – 3:30 PM	109, 240 Wellesley St E
NEIGHBOURHOOD SERVICES		
JOB CLUB- Group and individual support	10AM-4PM,Mon- Friday	102,260 Wellesley St E
COMPUTER TRAINING-Intermediate	Jan 9th, Mon 10AM-12PM	109,240 Wellesley St E
CHILD MINDING TRAINING	Fri Jan 27 2017	109,240 Wellesley St E
NEW! BEAUTICIAN TRAINING 6 weeks	Jan 28 11AM-1PM	102,260 Wellesley St E
PUBLIC SPEAKING 6 weeks	Thurs Feb 9 12:45-3:15 PM	102,260 Wellesley St E
COMMUNITY WORKER TRAINING 8 weeks	Tues Feb 7 12:30-2:30PM	102,260 Wellesley St E
JOBS FOR INTERNATIONAL HEALTH PROFESSIONALS	New Session Starts in March	102,260 Wellesley St E
CITIZENSHIP- group and test preparation	Monday 6:00 to 7:00PM	102,260 Wellesley St E
ENGLISH CAFE	Tuesday 1:00 to 3:00PM, Wed 6:00 to 7:30PM	102,260 Wellesley St E
St. JAMES TOWN ARTS	Ongoing:murals &festivals	102,260 Wellesley St E
• **KNITTING**	Thurs 11AM-1PM	
AFTER SCHOOL PROGRAM	Mon-Friday 3:15- 6:00PM	Rose Ave. Public School
Income Tax Clinics	March 1- April 30, 2017	102,260 Wellesley St E

3.Program Curriculum

Program/Training Background	

Program/Training Name:	
Capacity:	**# of people:**
Length:	**# sessions # hours each**
Logistics:	**Dates:** **Time:** **Location:**
Description:	
Learning Objectives:	
Who Should Attend:	
Other Considerations:	
Pre-Work:	

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Workshop Preparation Checklist Cont.	
Flip Charts	**Handouts**
Session 1	**Session 1**
☐	☐
☐	☐
☐	☐
☐	☐
Session 2	**Session 2**
☐	☐
☐	☐
☐	☐
☐	☐
Session 3	**Session 3**
☐	☐
☐	☐
☐	☐
☐	☐
Session 4	**Session 4**
☐	☐
☐	☐
☐	☐
☐	☐
Session 5	**Session 5**
☐	☐
☐	☐
☐	☐
☐	☐

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(Add in content and methods for each of the program modules) EXAMPLE:

Timing	Process / Content / Outputs	Method and Materials	Resp.
10mins	**<u>Upfront Activities:</u>** Welcoming , establishing the rules of the group and pre test	Pretest	
10mins	Ice breaker activity Introduce yourself and share one positive thing you did today(one thing you are happy about today)	Use the circle Power point presentation	
30 mins	Stress awareness Engaging the audience in identifying types of stress, symptoms of stress etc…		
15mins **5mins** **20mins**	discussion what is next cooking and socializing activity	One participant will teach the group how to make cookies will bake it @ the office together Aicha agreed to introduce a healthy soup recipe.	
<u>Outputs from this section:</u>	<u>Prep Upcoming</u>		

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Evaluation Pre and Post test

My personal goal for this program is:	
My rating of my goal: Before the session **After the session**	1 2 3 4 5 6 7 1 2 3 4 5 6 7 Poor Excellent

Please answer the questions below so you and Community Matters understand what you learned.

Self-Evaluation Questions	Rating Scale 1- 7						
	Do Not Agree						Strongly Agree
My overall health is good.	1	2	3	4	5	6	7
I am physically active.	1	2	3	4	5	6	7
My level of stress is good.	1	2	3	4	5	6	7
In general I am in a good mood.	1	2	3	4	5	6	7
I am socially active.	1	2	3	4	5	6	7
I can get help from friends, family and neighbours when needed.	1	2	3	4	5	6	7
In an average week I often visit or stop to chat with my neighbours or friends.	1	2	3	4	5	6	7
I am comfortable talking in a group.	1	2	3	4	5	6	7
I understand Canadian Culture (small talk, weather, school system)	1	2	3	4	5	6	7
I know how to live a healthy lifestyle.	1	2	3	4	5	6	7
I am satisfied with my life.	1	2	3	4	5	6	7
Please answer once the program ends:							
I will continue to connect with friends and family once the class is over.	1	2	3	4	5	6	7

Your feedback is very important to us. Please answer the questions below so we can improve our program!

	Rating Scale 1- 7

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WORKSHOP FEEDBACK		Do Not Agree						Strongly Agree
I learned what I came to learn.		1	2	3	4	5	6	7
There was a balance between listening and doing in the workshop.		1	2	3	4	5	6	7
The number and length of each session was just right.		1	2	3	4	5	6	7
The materials (slides and handouts) were good quality.	N/A	1	2	3	4	5	6	7
The instructor was well prepared.		1	2	3	4	5	6	7
The instructor covered the material clearly and kept me interested.		1	2	3	4	5	6	7
The instructor was able to answer my questions.		1	2	3	4	5	6	7
I met someone from a different culture and will try to stay in touch.		1	2	3	4	5	6	7
I would recommend this workshop to others.		1	2	3	4	5	6	7

What feedback do you have for us? (for example, what was most helpful?, what knowledge or skills will you continue to use?, and what changes would you recommend?)

THANKS FOR YOUR FEEDBACK!

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Program participant contact Sheet for Attendance

Program Name:		Program information Day: Time:							
Program Facilitator's Name:		Program Facilitator's contact information:							
Participant Name	Participant Phone #	Date							

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5b Motivational Scale and Background Material

Healthy Living **Establishing a Baseline for Behaviour Change** **CA: _____**					
Participant's Goal	**Pre Date:**		**Post Date:**		**Observations** (what worked? Ongoing support, other role models, buddy, small successes etc.)
	Goal 1-7	**Motivation 1-4**	**Goal 1-7**	**Motivation 1-4**	
Name and Registration Number					

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The Patient Activation Measure Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think the doctor wants you to say

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Healthy Living-Changing My Behaviour	**Name**	**Date**				
	If the statement does not apply to you, circle N/A	Disagree	Strongly disagree	Agree	Strongly Agree	N/A
Level 1	1. When all is said and done, I am the person who is responsible for taking care of my health					
	2. Taking an active role in my own health care is the most important thing that affects my					
Level 2	3. I am confident I can help prevent or reduce problems associated with my health					
	4. I know what each of my prescribed medications do					
	5. I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.					
	6. I am confident that I can tell a doctor concerns I have even when he or she does not ask.					
	7. I am confident that I can follow through on medical treatments I may need to do at home					
	8. I understand my health problems and what causes them.					
Level 3	9.I know what treatments are available for my health problems					
	10.I know how to prevent problems with my health					
	11. I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising					
Level 4	12. I am confident I can figure out solutions when new problems arise with my health.					
	13. I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.					

*''Summary of the Evidence on Performance of the Patient Activation Measure'' (PAM) May 2012
http://selfmanagementsupport.health.org.uk/media_manager/public/179/SMS_resource-centre_publications/PatientActivation-1.pdf

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Life Steps; An Evidence Based Health Promotion Program for Underserved Populations-A Community Service Learning Approach The Open Journal of Occupational Therapy Vol. 3 Issue 2 Spring Article 8 pp 1-13

References

1. Self-Management and Health Care Utilization Do Increases in Patient Activation Result in Improved Self-Management Behaviors? Judith H. Hibbard, Eldon R. Mahoney, Ronald Stock, and Martin Tusler Health Research and Educational Trust DOI: 10.1111/j.1475-67
2. PP presentation of the PAM

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Health Program Checklist

Level 1 (Self-care)

- Intervention focuses on general population
- Intervention focuses on connection to the health care system
- Intervention focuses on primary prevention education
- The GOAL is to prevent chronic dieses from occurring

Level 2 (Routine-care)

- Intervention focus on those seniors at high risk of developing chronic disease
- Intervention focuses on delaying the progress of chronic disease
- Intervention focuses on secondary prevention
- The GOAL is to reduce risk factors of developing chronic disease

Level 3 (Semi-Specialized care)

- Intervention focuses on those seniors who are diagnosed and living with chronic disease
- Intervention focuses on disease management, referrals and health care service coordination
- Intervention focuses on tertiary prevention
- The Goal is to manage chronic disease and to reduce further disease related complications

Level 4 (Highly-Specialized care)

- Intervention focuses on the vulnerable population
- Intervention focuses on seniors who are living with one and more chronic disease and disease related complications
- Intervention focuses on client centered aproach and coordinating support for daily living
- Intervention focuses on highly supervised support for one or more chronic disease management
- The GOAL is to prevent further progression or onset of other physical and/or mental chronic conditions

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Phases for each level of programming remain the same.

Phase 1: Identify needs & resources • Outreach and engage seniors • Identify priority • Gather information on needs/barriers • Set goals and objectives • Develop an inventory of resources • Identify partners/service providers	**Phase 3: Implementation** • Addressing the health needs • Selection of activities/workshops • Planer's involvement • Roles and responsibilities of team members • Engagement/participation strategies • Develop strategies to measure progress
Phase 2: Project Planning • Design intervention which incorporate health promotion theory, primary prevention education and connection to the health care system • Secure funds and confirm resources • Develop partnership • Develop team including staff and volunteers • System navigation and health care service coordination	**Phase 4: Evaluation** • Measure success • Pre and post indicators • Follow up after completion • Strategies to support seniors to measure progress on individuals stated goals • Measure progress on project stated goals
Always remember your limitations on accessing individual's personal information and medical health record.	

Details on Level 1

Phase 1

- Engage **all seniors,** conduct community landscape analyses and determine the need of a health promotion program
- Identify priority chronic diseases for which you would like to develop intervention
- Set project specific and level specific SMART goals and objectives (the goal is to maintain a healthy life and prevent specific chronic diseases)
- Develop an inventory of related resources and identify potential partners

Phase 2

- Design intervention strategies
- Incorporate health promotion theory that focuses on primary prevention, connection to the health care system, and evidence-based programming strategies
- Secure funds and confirm resources by creating a good project plan, with clearly stated goals and a clear implementation plan along with a well described process evaluation plan (impact)
- Develop partnership, identify team members and confirm their roles and responsibilities. Also, provide trainings if required.
- System navigation, referrals and health care service coordination by developing strategies to connect seniors with appropriate level of health care services and family physicians
- Identify strategies to track referrals and participants' behaviour change progress

Phase 3

- Select activities focuses on primary prevention of chronic disease and develop project implementation strategies
- Establish seniors' participation and the coordinator/planner's involvement during the implementation
- Assist seniors in setting individual goals which reinforce project goals
- Develop strategies to monitor intervention/activities are occurring according to plan (process evaluation) and to measure progress
- Evaluation of team members as well as the program through feedback from participants about the activities

Phase 4

- Process to collect and review data
- Measuring success (Pre indicators and Post indicators)
- Measure progress on project stated goals
- Support seniors to measure progress on individuals stated goals

Details on Level 2

Phase 1

- Engage those seniors **who are at risk of developing chronic diseases** and determine the extent of the problem within the community
- Set project specific and level specific SMART goals and objectives
- Develop an inventory of resources specific to your community, chronic disease and intervention level
- Identify potential partners, e.g. the disease specific education team along with the family physician
- Identify strategies to engage seniors and identify the process of service delivery

Phase 2

- Design intervention strategies such as one-on-one meetings or small group sessions
- Incorporate a health promotion theory that focuses on secondary prevention education, reduce risk factors, delay the progress of disease and enhance self-management skills
- Secure funds and confirm resources by creating a good project plan, with clearly stated goals and a clear implementation plan along with a well described process evaluation plan (impact)
- Identify roles and responsibilities, including boundaries, of team members and train staff/volunteers
- System navigation, referrals and health care service coordination by developing strategies to engage family physicians, caregivers and appropriate health care team
- Identify strategies to track referrals and participants' behaviour change progress

Phase 3

- Select activities focuses on secondary prevention and develop project implementation strategies
- Establish seniors' participation and the coordinator/planner's involvement during the implementation
- Support seniors in setting individual goals which reinforce project goals
- Develop strategies to monitor intervention/activities are occurring according to plan (process evaluation) and to measure progress
- Evaluation of team members as well as the program through feedback from participants about the activities

Phase 4

- Process to collect and review data
- Measuring success (Pre indicators and Post indicators)
- Measure progress on project stated goals
- Support seniors to measure progress on individuals stated goals

Details on Level 3

Phase 1

- Engage those seniors **who are diagnosed, living with chronic disease** and need support for disease management
- Identify individuals barriers for disease management and develop intervention such as referral to appropriate services or referral to case worker for one-on-one support or connection to self-management skill building group sessions)
- Set project specific and level specific SMART goals and objectives
- Identify partners such as disease management team, family physician, specialist, pharmacist or other appropriate health care services)
- Identify strategies to engage seniors (incentivized programming), develop an inventory of resources

Phase 2

- Design intervention such as group workshops focus on tertiary prevention and identify the process of service delivery
- Incorporate health promotion theory through cultural expertise, where community health focuses on secondary and tertiary prevention education and chronic disease management
- Secure funds and confirm resources by creating a good project plan, with clearly stated goals and a clear implementation plan along with a well described process evaluation plan (impact)
- Identify roles and responsibilities, including boundaries, of team members and train staff/volunteers
- System navigation, referrals and health care service coordination:
    - Strategies to engage seniors for better chronic disease management, engage family doctor, caregiver, specialist, and/or disease management team
    - Identify strategies to track referrals health care service coordination
    - Strategies to motivate seniors for stating individuals goal

Phase 3

- Select activities focuses on tertiary prevention, delaying disease progression and develop project implementation strategies
- Establish seniors' participation and the coordinator/planner's involvement during the implementation
- Support seniors in setting individual goals which reinforce project goals
- Develop strategies to monitor intervention/activities are occurring according to plan (process evaluation) and to measure progress
- Evaluation of team members as well as the program through feedback from participants about the activities

Phase 4

- Process to collect and review data
- Measuring success (Pre indicators and Post indicators)
- Measure progress on project stated goals and track referrals on health care service coordination
- Support seniors to measure progress on individuals stated goals

Details on Level 4

Phase 1

- Engage **those seniors with greater complexity who are isolated, have difficulty coping, are living with one or more chronic disease-related complications, have a disability, impairment, or other type of dependency**
- Identify individual needs for daily living and identify resources/services to support seniors (services should be tailored to seniors individual needs)
- Set project specific and level specific SMART goals and objectives and focus on tertiary prevention e.g. assist seniors to manage complicated, long-term health problems
- Develop an inventory of senior's support services, e.g. social workers, personal support worker, transportation, counselling, crisis support, friendly visiting, home making, Meals On Wheels, security checks
- Identify service providers and the process of service delivery
- Develop a plan to track referrals and service coordination

Phase 2

- Design intervention such as group workshops focus on tertiary prevention and identify the process of service delivery
- Incorporate knowledge of culture, aging, disease-related complexity, and complexities around frailty to design an intervention for a vulnerable population
- Secure funds and confirm resources by creating a good project plan, with clearly stated goals and a clear implementation plan along with a well described process evaluation plan (impact)
- Identify roles and responsibilities, including boundaries, of team members and train staff/volunteers
- Develop strategies to engage care coordination team and required support services for daily living
- Identifying strategies to track service coordination and referrals

Phase 3

- Identify coordinator involvement during the intervention
- Identify strategies to engage service providers and to monitor intervention process and outcomes (process evaluation)
- Assist seniors in setting individual goals which reinforce project goals and follow-up if their needs are met and also on referrals
- Strategies to coordinate services and support to monitor individual's health condition

Phase 4

- Process to collect pre and post data
- Measure progress on project's stated goals and objectives
- Measure progress on project stated goals and track referrals on service coordination

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Healthy Living	Establishing a Baseline for Behaviour Change				CA: Bhavana Mahajan
Participant's Goal	**Pre Date:**		**Post Date:**		**Observations** (what worked? Ongoing support, other role models, buddy, small successes etc.)
	Goal 1-7	**Motivation 1-4**	**Goal 1-7**	**Motivation 1-4**	
1. Zinat N. a. fit in Healthy BMI range (6mnths) (16/07/15) b. to improve English (3mnths) (25/06/10) c. Increase veg/fruits intake – 5/day (3mnths) d. Improving knowledge about healthy pregnancy pre and post.	a. 3 b. 4 c. 2 d. 1	2 2 1 3	a. 5 a. 5 c. 3	4 4 3	a. Ongoing support, information on healthy diet, suggesting some physical activities which are interesting like dance, walking with friends, role model (Surabhi). Joined walking group. b. Connected with Sarah's English café, Buddy (Sulekha) c. Reminding her to eat more fruits and vegetables almost every day...set a reminder for it, had a discussion of benefits from vegetables and fruits in a social support group. d. Connected with Growing Together's Pre and Post natal program from October, exchanging information in social support group, Buddy (N.B.)
2. Priyanka K. a. improve English (3mnths) (27/7/15) b. fit into healthy BMI range (4mnths) (27/7/16) c. same as goal "b" (3/11/15) d. knowledge about Diabetic diet (3mnths) (1/4/16) e. get 3hrs/week exercise (3mnths) f. get 5hrs/week exercise even in winter time. (4months) (14/10/16)	a. 2 b. 2 c. 2 d. 2 e. 3 f. 5	3 2 3 3 4 4	a. 3 b. 2 c. 3 d. 3 e. 5 f. 6	4 3 4 4 4 4	Connected with Angela and going regularly…initially I was calling her as a reminder for a class but now she is interacting with Angela by herself. Till date (11/11/16) she is very regular and improving her English. Ask her to attend more programs by CMTs to learn how to communicate. b. c. e n f. Ongoing support and diet information did not work for first months but after a follow-up we started to have discussion about diet habits and how much changes we needed in the use of oil and butter along with a time she is spending for a physical activity. At the end we decided to change oil and butter habits little bit (baby steps) and add physical active hours in daily routine. She joined Walking group with a role model Surabhi. Started to send reminder massages for Bollywood dance. d. connected with the dietitians from Reagent park. Coming regularly for monthly sessions. Had a discussion about healthy diet in Social support.

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Your Smile Matters Screening

To start, some questions about the general health and appearance of your teeth and mouth:

A. What is/are your oral health goals in your own words	I rate myself on my goal	
	Now	Later_____Date
	Poor 1 2 3 4 5 6 7 Good	Poor 1 2 3 4 5 6 7 Good

B.In general the health of my mouth/teeth is (Circle one)	1. Poor	2. Fair	3. Good	4. Very Good 5. Excellent
C. How satisfied are you with the appearance of your teeth/dentures (Circle one)	1. Very Dissatisfied	2. Dissatisfied	3. Satisfied	4. Very satisfied
D. Do you have ? (Circle one)	1. A full set of dentures (upper and lower jaw) 2. 2. Some of your own teeth and partial dentures or bridges 3. All your own teeth			
E. In the past month, have you had (Circle all that apply to you)	1. A toothache? 2. Pain in your teeth when consuming hot or cold foods or drinks? 3. Severe tooth or mouth pain at night? 4. Pain in or around your jaw joints? 5. Bleeding gums when brushing your teeth? 6. Persistent dry mouth? 7. Persistent bad breath? 8. Discomfort when you eat food?			
F. I can eat/chew any foods I want (Circle One)	Yes	No		
G. I am happy with my smile (Circle One)	Yes	No		
H. I have had cavities which have been filled (Circle One)	Yes	No		
I.When was the last time that you went to a dental professional(Circle One)	1. Less than a year ago 2. More than 1 year but less than 2 years ago 3. More than 2 years but less than 3 years ago 4. More than 3 years but less than 4 years ago 5. More than 4 years but less than 5 years ago		6. 5 or more years ago 7. Never 8. Don't Know	

J.Do you usually visit a dental professional? (Circle One)	K.What reason would you not go to a dental professional?
1.More that once a year for check-ups or treatment 2. About once a year for check-ups or treatment 3. Less than once a year for check-ups or treatment 4. Only for emergency care 5. Don't know/ Refused answer	1. Cost 2. Fear 3. Distance 4. Don't know how to find a good one 5. Other

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L.Do you have insurance that covers all or part of your dental expenses (Circle One)	Yes	No
If yes to the above question. The insurance plan is a/an (Circle One)	1. Government program for social service (welfare) clients 2. Government program for children or seniors in this province or territory 3. Government program for First Nations people 4. Employer-paid plan from [my/his/her] or [my/his/her] spouse's employment 5. Retirement plan through [my/his/her] or [my/his/her] spouse's previous employer paid for by [me/him/her] or [my/his/her] spouse 6. Other (Please, specify)	

Screening Results_____Screener_____Date:

1. Screening Results this section to finished by Bobby and Usha	Caries Gum Breath Dental practices Other

2. Follow up Steps

1. How to contact the person for follow up? Phone _____ Email_____
   Social media (eg FB and What's App)_____
2. Referral to _____(Name, Address, Phone)

Help needed for a successful referral:

_____Referral Information- contact the referral source to set up an appointment, negotiate fees, arrange for support
_____Reminder System
_____Accompaniement and appointment support

3. CMT Follow up____Follow up clinic at CMT ____CMT Workshop ____Forms (dentures, subsidies) ____Translation ____Advocacy, Other_____

_____Interest in Healthy Living programs(List)_____
_____Interest in Health Planner
_____Interest in other Community programs(List)_____

4. Follow up date	**Comments**
Follow up date	**Comments**
Follow up date	**Comments**
Follow up date	**Comments**
Community Assistant	
Screening Date	

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HEALTH PLANNER CHEKLIST

Participant Name:	Community Assistant Name:	
Telephone Number	E Mail	Date of Birth dd/mm/yyy

A Participant Planner Information

1. Body Mass Index	□ 18,5 – 24.9	□ 25 – 29.9	□ 30+	□ Don't know
2. Exercise	□ Active	□ Moderate	□ Inactive	□
3. Serving fruits and vegetables per day	□ < 5	□ 5 – 7	□ 7+	
4. Smoking □ Yes □ No	□ daily □ Occasionally □ Intends to quit and has stopped for 24h in the last 12months □ Exposed to second hand smoke at home			
5. Drink Alcohol □ Yes □ No	□ More than 4 drinks at a time	□ More than 14 drinks per week		

6. Motivation: Participant Activation Measure

□ Believes active roles is important □ Has confidence and knowledge to act alone □ Is taking action □ Is staying the course under stress

7. Use of health practices from back home : □ Yes □ No

□ Natural products □ Meditation □ Deep breathing Massage □ Yoga □ Chiropractic □ Osteopathy □ Diet based therapy
□ Homeopathy Guided imagery □ Progressive relaxation □ Ayarvedec □ Faith/Belief □ Acupuncture □ Acupressure/Trigger Point
□ Others:……

8. Behaviours: Knowledge and skills

Methods □ Stress-Management □ Problem Solving □ Relaxation □ Cognitive re-structuring □ Social Networks □ Self-Motivation □ Others:……..

9. Family History

□ Asthma □ High Blood Pressure □ Diabetes □ Heart Problems □ Chronic Obstructive Pulmonary Disease □ Others :……..

B. Screening

Women over 50: **Did you have Mammogram and clinical breast exam?** □ Yes □ No

If yes when

Women Over 21: **Have you had a Pap Test** □ Yes □ No

If Yes When

COMMUNITY MATTERS TORONTO 260 Wellesley St. East, Unit 102, Toronto, ON M4X 1G6
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registered charity #85629 8005 RR0001

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HEALTH PLANNER CHEKLIST

Participant Name:	Community Assistant Name:

3. Participant over 50: **Did you have Colorectal FOBT?** □ Yes □ No

If yes When

4. Participant had the Can Risk assessment for Diabetes □ Yes (**Score was**:.....) □ No

Do you have a family history of diabetes ☐ Yes ☐ No

C. Community Assistant Roles

□ Accompaniment □ Translation □ Planning □ Telephone/Text/FB/email/social media

Referral to community resources: ☐ Follow up ☐ Direct Support ☐ Group □ Other

		Pre	Post
Goal	**1**		
	2		
	3		

Participation in CMT Programs: Please provide program name and date enrolled

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CMT Registration Complete: □ Yes □ No

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COMMUNITY MATTERS TORONTO
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Revision Date: July 16, 2015

Community Matters Toronto

Timesheet

Employee and Volunteer : **Binita Subedi**

2016

Month		**November**
Kamala	Thapa	55 min
Urmila	Gajurel	25min
Sarada	Karki	-
Tika	Paudel	30 min
Sushma	Subedi	22 min
Pabita	Basnet	_
Sujata	Kafle	25 min
Gyanu	Shah	35 min
Neha	Baht	45 min
Saru	Neupane	50 min
Sarita	Gnayawall	10 mn
Ganga	Bhandari	35 min
Aruna		
Usha	Sedhai	20 min
Goma	Dahal lohani	25 min
Ingrid		15 min
Radhika	Balmiki	25 min
Maya	Adhakari	45 min
Susmita	Mainali	10 min
Hari	Lohani	30 min
Jyoti	M	-
Ansu	Garge	25 min
Rina	M	33 min
Kamala	B	15 min
Smita	M	50 min
Meeli		25 min
Pryemada Achrya		20 min
Kushum Bhatta		30 min
Meetings		6 hrs

Socials	4 hrs
Traning	7 hrs
Program delivery	16 hrs
Office coverage	
PAP	8 hrs
Mamo	6 hrs
Total	**50 hrs**