Ontario Health Teams
Full Application Form

Introduction

Thank you for your interest and effort to date in becoming an Ontario Health Team.

Ontario Health Teams will help to transform the provincial health care landscape. By building high-performing integrated care delivery systems across Ontario that provide seamless, fully coordinated care for patients, Ontario Health Teams will help achieve better outcomes for patients, improved population health, and better value for the province.

Based on the evaluation of Self-Assessment submissions, your team has been invited to submit a Full Application, which is the next stage of the Ontario Health Team Readiness Assessment process.

In the Self-Assessment stage, your team collectively assessed its ability to meet the minimum readiness criteria to become an Ontario Health Team, as set out in *'Ontario Health Teams: Guidance for Health Care Providers and Organizations'* (Guidance Document). This Full Application builds off the Self-Assessment. In this stage, your team is being asked to propose plans and provide detailed **evidence** of what you previously assessed that you could do.

This application form consists of seven sections and two appendices:

1. About your population
2. About your team
3. How will you transform care?
4. How will your team work together?
5. How will your team learn and improve?
6. Implementation planning and risk analysis
7. Membership Approval

Appendix A: Home & Community Care
Appendix B: Digital Health

The form is designed to provide reviewers with a complete and comprehensive understanding of your team and its capabilities and capacity. **The questions in this form are aligned to the eight components of the Ontario Health Team model and the corresponding minimum readiness criteria set out in the Guidance Document.** For any readiness criteria in the Guidance Document that referenced:

- your ability to propose a plan, you are now asked to **provide that plan**;
- a commitment, you are asked to **provide evidence** of past actions aligned with that commitment; and

- a demonstrated track record or ability, you are asked to **provide evidence** of this ability.

Please read and fully respond to the questions. Clear, specific responses and the use of verifiable examples and evidence are encouraged.

Note that a core component of the Ontario Health Team model is alignment with the *Patient Declaration of Values for Ontario*, as well as comprehensive community engagement. This form includes discrete questions related to patient partnership and community engagement, but your team is also encouraged to consider patient, family and caregiver perspectives and opportunities for patient partnership and community engagement throughout your submission.

The Readiness Assessment process will be repeated until full provincial scale is achieved. The first group of Ontario Health Team Candidates will help set the course for the model's implementation across the rest of the province. Although the core components of the model will remain in place over time, lessons learned by these initial teams will help to refine the model and implementation approach and will provide valuable information on how best to support subsequent teams. The first Ontario Health Team Candidates will be selected not only on the basis of their readiness and capacity to successfully execute the model as set out in the Guidance Document, but also their willingness to champion the model for the rest of the province.

Applications will be evaluated by third-party reviewers and the Ministry of Health (the Ministry or MOH) according to standard criteria that reflect the readiness and ability of teams to successfully implement the model and meet Year 1 expectations for Ontario Health Team Candidates, as set out in the Guidance Document.

Following evaluation of the Full Application there are two possible outcomes. Teams will either: 1) be invited to move to the final stage of evaluation, or 2) continue to work towards readiness as a team 'In Development'. Those teams that are evaluated as being most ready to move to the final stage of evaluation may also be invited to participate in community visits, which will then further inform the final selection of the first cohort of Ontario Health Team Candidates.

Information to Support the Application Completion

Strengthening the health care system through a transformational initiative of this size will take time, but at maturity, Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a defined population of Ontario residents, and will be accountable for the health outcomes and health care costs of that population. Identifying the population for which an Ontario Health Team is responsible requires residents to be **attributed** to care providers and the method for doing so is based on

analytics conducted by ICES. ICES has identified naturally occurring networks of residents and providers in Ontario based on an analysis of existing patient flow patterns. These networks reflect and respect the health care-seeking-behaviour of residents and describe the linkages among residents, physicians, and hospitals. An Ontario Health Team does not have to take any action for residents to be attributed to their Team. As per the ICES methodology:[1]

- Every Ontario resident is linked to their usual primary care provider;
- Every primary care physician is linked to the hospital where most of their patients are admitted for non-maternal medical care; and
- Every specialist is linked to the hospital where he or she performs the most inpatient services.

Ontario residents are not attributed based on where they live, but rather on how they access care which is important to ensure current patient-provider partnerships are maintained. However, maps have been created to illustrate patient flow patterns and natural linkages between providers which will help inform discussions regarding ideal provider partnerships. While Ontario Health Teams will be responsible for the health outcomes and health care costs of the entire attributed population of one or more networks of care, there will be no restrictions on where residents can receive care. The resident profile attributed to an Ontario Health Team is dynamic and subject to change over time as residents move and potentially change where they access care.

To help you complete this application, your team will be provided information about your attributed population.

Based on resident access patterns and the end goal of achieving full provincial coverage with minimal overlap between Ontario Health Teams, the Ministry will work with Teams over time to finalize their Year 1 target populations and populations at maturity.

Participation in Central Program Evaluation

To inform rapid cycle learning, model refinement, and ongoing implementation, an independent evaluator will conduct a **central program evaluation** of Ontario Health Teams on behalf of the Ministry. This evaluation will focus on the development and implementation activities and outcomes achieved by Ontario Health Team Candidates and a selection of teams In Development. Teams are asked to indicate a contact person for evaluation purposes.

[1] Stukel TA, Glazier RH, Schultz SE, Guan J, Zagorski BM, Gozdyra P, Henry DA. Multispecialty physician networks in Ontario. Open Med. 2013 May 14;7(2):e40-55.

Additional Notes

- Details on how to submit your application will be provided by the Ministry.
- Word limits are noted for each section or question.
- Up to 20 pages of additional supplementary documentation are permitted; however, supplementary documentation is for informational purposes only and does not count towards the evaluation of applications.
- To access a central program of supports coordinated by the Ministry, please visit: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/default.aspx or reach out to your Ministry point of contact.
- The costs of preparing and submitting a Self-Assessment and a Full Application or otherwise participating in this Ontario Health Team Readiness Assessment process (the "Application Process") are solely the responsibility of the applicant(s) (i.e., the proposed Ontario Health Team members who are signatory to this document).
- The Ministry will not be responsible for any expenses or liabilities related to the Application Process.
- This Application Process is not intended to create any contractual or other legally enforceable obligation on the Ministry (including the Minister and any other officer, employee or agency of the Government of Ontario), the applicant or anyone else.
- The Ministry is bound by the *Freedom of Information and Protection of Privacy Act (*FIPPA) and information in applications submitted to the Ministry may be subject to disclosure in accordance with that Act. If you believe that any of the information that you submit to the Ministry contains information referred to in s. 17(1) of FIPPA, you must clearly mark this information "confidential" and indicate why the information is confidential in accordance with s. 17 of FIPPA. The Ministry would not disclose information marked as "confidential" unless required by law.

  In addition, the Ministry may disclose the names of any applicants for the purposes of public communication and sector awareness of prospective teams.
- Applications are accepted by the Ministry only on condition that an applicant submitting an application thereby agrees to all of the above conditions and agrees that any information submitted may be shared with any agency of Ontario.

Ontario Health Teams
Full Application Form

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Anne Babcock
	Title: President and CEO
	Organization: WoodGreen Community Services
	Email: ababcock@woodgreen.org
	Phone: 416-645-6000 ext 1102
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Anne Wojtak
	Title: Interim Lead, East Toronto Health Partners
	Organization: Michael Garron Hospital (Toronto East Health Network)
	Email: Anne.Wojtak@tehn.ca
	Phone: 416-469-6580 ext 2349

1. About Your Population

In this section, you are asked to provide rationale and demonstrate your understanding of the populations that your team intends to cover in Year 1[2] and at maturity.

Note: Based on patient access patterns and the end goal of achieving full provincial coverage with minimal overlap between Ontario Health Teams, the Ministry will work with Teams to finalize their Year 1 populations and populations at maturity.

1.1. Who will you be accountable for at maturity?

Recall, at maturity, each Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a attributed population of Ontario residents, and will be accountable for the health outcomes and health care costs of that population.

Your team will be provided with information about its attributed population based on most recent patient access and flow data. These data will include attributed population size, demographics, mortality rates, prevalence of health conditions, utilization of health services by sector, health care spending data, etc.

Also, recall that in your Self-Assessment, your team proposed a population to care for at maturity.

[2] 'Year 1' is unique to each Ontario Health Team and refers to the first twelve months of a team's operations, starting from when a team is selected to be an Ontario Health Team Candidate.

Below, please rate the degree of alignment between the population and service area that your team originally proposed during the Self-Assessment and your team's attributed population (high, moderate, low). Where alignment is moderate or low, please explain why your initial proposed population may have differed.

Considering given information about your attributed population and any other data sources you may have, what opportunities and challenges (both in Year 1 and longer-term) does your team foresee in serving and being accountable for your attributed population as you work towards maturity? In your response, reflect on whether your team has experience implementing a population health approach or if this is a competency that will need to be developed. Note: If there is discrepancy between the given information about your attributed population and data that your team has, please comment on the difference below.

Maximum word count: 1000

Alignment of Attributed Population:

The East Toronto Health Partners (ETHP) will be responsible for approximately 375,000 people in its attributed population at maturity.

The attributed population has a reasonably high degree of alignment with the service area that our team proposed in the Self-Assessment. We had described our primary population of focus geographically, encompassing the residents of 21 neighbourhoods in East Toronto with a total population of 300,000. The attributed population (375,000 individuals) stretches beyond the East Toronto geography and includes patients connected to our network through local primary care physicians; these patients may reside outside of the East Toronto area.

The difference between the geographic and attributed populations is not material to the work we are committed to do as partners in patient care. Given our positioning in a large urban centre, it is a given that patients have high mobility and that patients access health care services across the metropolitan area for a variety of reasons. In our Self-Assessment, the ETHP expressed our responsibility to the people who live in East Toronto but also to all those who seek care in East Toronto.

Opportunities:

Our partnership includes a recently established Family Practice Network (East Toronto Family Practice Network – EasT-FPN) that seeks to engage all family physicians in East Toronto and to become the 'voice' of family practice, supporting engagement of primary care in the design and development of a local integrated model of care. Leadership and engagement of primary is an essential building block for an integrated system. As of October 2019, 173 family physicians are formally

engaged and involved in this Family Practice Network. The Network is positioned to provide leadership across family practice in designing and spreading models of integrated care within our Year 1 populations, and in identifying barriers and system inefficiencies that our patients face daily.

It is important to note that the EasT-FPN joined as an Anchor Partner to ETHP in October 2019. Throughout this application there are references to the work of the ETHP which pre-date the inclusion of EasT-FPN as a member, therefore, references to the work to date of the ETHP do not include the EasT-FPN unless otherwise stated.

Challenges:

The attribution model poses specific challenges for Ontario Health Teams (OHTs) based in large urban environments. Close collaboration will be required with the Ministry and other OHTs to develop sector-leading practices for understanding and becoming responsible for attributed populations.

Patient choice brings a high degree of mobility across OHTs; patients commute to Toronto and seek care based on proximity to their place of employment. Patients also change their places of employment and/or residence while retaining previously established health-care relationships. This patient choice will drive the need for cross-OHT service relationships and force us to think innovatively and beyond previous geographic catchment areas.

When real-time person-level data becomes available, we will be able to more directly target our programs to particular segments of the attributed population and apply continuous improvement strategies to hone our efforts.

Population Health Approach:

The East Toronto Health Partners are ideally positioned to implement a population health approach. Dating back to the early 1990s, a range of health and social service providers came together to explore the development of a vertically integrated health care system; Toronto East General Hospital (now Michael Garron Hospital – Toronto East Health Network) and South Riverdale CHC were part of that initial partnership, as was Toronto Public Health. This was then called Partners for Health, which ultimately framed the creation of ‘Silos for Solutions’ 20 years ago, more recently called ‘Solutions’. https://solutionshealthcollaborative.ca

Following the guidance offered in the RISE webinars, the East Toronto Health Partners recognize that geographic, neighbourhood-based approaches are a practical way to advance population health for the larger population overall.

1.2. Who will you focus on in Year 1?

Over time, Ontario Health Teams will work to provide care to their entire attributed population; however, to help focus initial implementation, it is recommended that teams identify a Year 1 population to focus care redesign and improvement efforts. This Year 1 population should be a subset of your attributed population.

To support the identification of Year 1 areas of focus, you will be provided with information about your attributed population including health status and health care spending data.

Describe the proposed population that your team would focus on in Year 1 and provide the rationale for why you've elected to focus on this population. Include any known data or estimates regarding the characteristics of this Year 1 population, including size and demographics, costs and cost drivers, specific health care needs, health status (e.g., disease prevalence, morbidity, mortality), and social determinants of health that contribute to the health status of the population.

If this Year 1 population differs from the one you proposed in your Self-Assessment, please provide an explanation.

Maximum word count: 1000

Our goal is to create an integrated health system for the 375,000 people attributed to East Toronto. Our focus in Year 1 will be to integrate care for three initial populations:

1. Seniors with chronic care needs and caregivers: East Toronto has a significant population of seniors (53,712 or 14% of the attributed population) and heavy burden of chronic illnesses including Chronic Obstructive Pulmonary Disease (COPD – 3,937 people) and Congestive Heart Failure (CHF – 2,734 people). Seniors with chronic care needs experience high levels of hospital admissions, and long lengths of stay, contributing to hallway medicine pressures.

This population was selected because of the recognition of risk factors within the East Toronto seniors' population and the ability to implement elements of the Chronic Care Model to progress toward the quadruple aim. East End-Danforth and Thorncliffe Park neighbourhoods include over 40% of seniors living alone. Caregiver distress is particularly high, at up to 47%, in specific East Toronto neighbourhoods.

The redesign of care for the seniors' population will also build on what we've heard from patients, families, caregivers, and health care providers around frustrations that are experienced around fragmented care and poor transitions of care.

In December 2018, we launched "Home 2Day" to transition COPD inpatients from MGH to home with enhanced home care service from WoodGreen and VHA Home HealthCare (VHA). Based on evidence we determined criteria for patients who would

have highest benefits and lowest risks when discharged from hospital after two days. This program includes 24/7 care navigation, virtual connection to specialists at Michael Garron Hospital (MGH), shared quality metrics, and connections to caregivers at home. In Year 1 we plan to expand this approach to patients with heart failure (2,734 people) and patients hospitalized for pneumonia (12,055 people) to return home sooner with support.

2. Youth Mental Health and Wellness: Certain neighbourhoods in East Toronto, such as Taylor Massey have 3 times higher Emergency Department (ED) use for youth mental health than the Toronto Central average. East Toronto has approximately 7,977 youth living with mental health conditions. Our work has focused on connecting youth to services upstream with a more preventative approach and improving connectivity between primary care providers and youth mental health and wellness providers to improve access to necessary services. In year 1 we will explore plans for expanding on our Youth Wellness Centre that opened in summer of 2019 to additional youth mental health centres in East Toronto.

3. Substance Use and Health: Most partners within East Toronto Health Partners provide significant levels of service for people with substance use. The Canadian Institute for Health Information (CIHI) identified 7,288 people in our attributed population with diagnosed Drug/Alcohol Dependency. There are effective approaches to improve health among people who are substance users; and often these individuals are disconnected from basic primary care, are vulnerable due to social determinants of health, and are at high risk of emergency room use or admission. Coordinated Harm Reduction, including Withdrawal Management, Rapid Access to Addictions Medicine, Mobile Crisis Intervention Teams and Crisis Services can be better coordinated to improve health for this priority population.

Our work with priority populations will be operationalized through a neighbourhood approach. East Toronto includes five “Neighbourhood Improvement Areas” as defined by the City of Toronto. An example of our work in one of these priority neighbourhoods is our partnership with Health Access Thorncliffe Park, a formal collaboration between Flemingdon Health Centre and The Neighbourhood Organization. Health Access Thorncliffe Park provides primary care, health and social services, and wraparound services to the Thorncliffe Park community, and is leading the development of a new multi-service neighbourhood centre scheduled to open in 2021. This approach to integrate primary care (linking fee-for-service physicians to team-based care hubs) together with community and neighbourhood services has been impactful and has resulted in better services to people living in the area. To address high usage of the hospital emergency department, and to better link inter-professional teams to local family physicians, the partners worked together to develop a Neighbourhood Care approach. In Year 1, we will expand access to neighbourhood-based inter-professional teams through our evolving Family Practice Network and community service partners. We will also be planning for inclusion of midwifery services as part of the evolution of our new Thorncliffe Park Hub related to developing more integrated care for our Year 2 population of perinatal care.

Of our total attributed population of 375,000, the 178 family practice physicians who have joined the new East Toronto Family Practice Network (EasT-FPN) care for approximately 200,000 patients. In addition, the priority populations for Year 1 aggregate to roughly 69,000 people.

- All of the 53,712 seniors within the attributed population
- All of the 7,288 individuals with a diagnosis of Alcohol or Drug Dependency
- A total of 7,977 youth living with mental health conditions (estimated 20% of the attributed population aged 15-24)

Through our members and the scope of services we provide, ETHP will provide actively coordinated care for roughly 20% of the total Year 1 population: a total of 13,800 individuals. In addition, the 200,000 residents who access primary care through family physicians who are part of EasT-FPN will have access to integrated care through our SCOPE program, interprofessional care teams, fall/winter community surge investments and other existing programs in East Toronto.

In Year 2, we will expand our focus to perinatal and pediatric care, including existing integrated midwifery care models, and to integrated palliative care. Combined with existing primary care, emergency care and home and community care services across ETHP, we will expand ETHP's integrated care to the full population of East Toronto, at maturity.

1.3. Are there specific equity considerations within your population?

Certain population groups may experience poorer health outcomes due to socio-demographic factors (e.g., Indigenous peoples, Francophone Ontarians, newcomers, low income, other marginalized or vulnerable populations, etc.). Please describe whether there are any particular population sub-groups within your Year 1 and attributed populations whose relative health status would warrant specific focus.

Maximum word count: 1000

Where known, provide information (e.g., demographics, health status) about the following populations within your Year 1 and attributed populations. Note that this information is not provided in your data support package. LHIN Sub-Region data is an acceptable proxy.[3] Other information sources may also be used if cited.

- Indigenous populations
- Francophone populations
- Where applicable, additional populations with unique health needs/status due to socio-demographic factors

[3] Sub-region data was provided by the MOH to the LHINs in Fall 2018 as part of the Environmental Scan to support Integrated Health Service Plans. This data is available by request from your LHIN or from the MOH.

Immigrants and Newcomers:
East Toronto has a high proportion of recent immigrants (6.7%) who arrived between 2011-2016. The top three countries of birth by recent immigrants were Bangladesh (13.7%), Philippines (12.0%), Pakistan (11.3%). The most common languages spoken at home other than English include Urdu, Bengali and Cantonese. There is wide variation in neighborhood rates of “no knowledge of the official languages,” ranging from only 0.2% (The Beaches) to 8.1% South Riverdale (a 40.5 times difference).

Patients who are Uninsured:
Within our population there are significant numbers of individuals who are uninsured, with 714 accessing Community Health Centres (CHCs) in East Toronto in 2016/17. Within our neighbourhoods, Victoria Village, Oakridge, and Taylor-Massey have notably high levels of marginalization.

Individuals and Families with Low Incomes:
Diverse housing conditions are evident within East Toronto. Within our neighbourhoods there are 61 Toronto Community Housing developments representing 387 buildings with a total of 4,418 units. Of these, 18 are Seniors Buildings with a total of 2,648 units. East Toronto has two shelters for homeless individuals, with a total of 116 beds.

Indigenous Peoples:
Although East Toronto does not have any land set aside for First Nations, it does have a significant Indigenous population of 13,778 people; however, we recognize the valuable work of 'Our Health Counts Toronto' in demonstrating that the most recent Canadian census underestimated the size of the indigenous population in Toronto by a factor of 2 to 4. In general terms, this population typically has higher rates of low income, and high rates of health and mental health conditions. Many of the ETHP have Aboriginal programs delivered in partnership with Aboriginal leaders and Elders. Moving forward, we will continue to engage with Aboriginal leaders and Elders, building on the principles of engagement of the Toronto Indigenous Health Strategy, to provide culturally appropriate and sensitive services to shape how we can better support and serve our Aboriginal community members and families in East Toronto. The ETHP is committed supporting the rights of our indigenous communities to self-determine how they will engage with the Ontario Health Team (OHT) work. Additional information about our engagement with our indigenous communities is in section 2.10.

Francophone Populations:
East Toronto is located within the City of Toronto, one of the 26 designated French Language Services (FLS) regions in Ontario (Ministry of Francophones Affairs). As such, the East Toronto Health Partners have included this region’s Francophone population into their equity considerations.

There are 7,130 Francophones living in the East Toronto sub-region (Health Analytics Branch, LHIN and Sub-Region Census Profile, 2016). The Francophone community is comprised of people with diverse cultural and ethnic backgrounds. Nearly half of Francophones living in East Toronto were not born in Canada (Office of Francophone Affairs, 2016). Most of East Toronto's Francophones live in the neighbourhoods of Woodbine Corridor and The Beaches (Toronto Central LHIN, 2016).

Of the 7,130 East Toronto Francophones, 19.5% are seniors (65 years and over) and more than 7.9% are 75 years and older, both higher than the general population in East Toronto (Health Analytics Branch, LHIN and Sub-Region Census Profile, 2016). This aging population requires specific services, such as long-term care, palliative care and other specialized services, including Adult Day Programs and Dementia Care, delivered in French, as seniors tend to revert back to their mother-tongue during end of life (Office of Francophone Affairs, 2011). Information about our engagement with our francophone communities is in section 2.10.

LGBTQIA2

The lesbian, gay, bisexual, trans, queer, intersex, asexual and two-spirit (LGBTQIA2) communities in Canada experience numerous health inequities. Health inequities are experienced differently by each of the LGBTQIA2 communities, but in general, these communities are more likely than heterosexual Canadians to develop mental health disorders, have suicidal thoughts and attempt suicide. A report from June 2019 reported that lesbian and bisexual women are more likely than heterosexual women to suffer from chronic diseases such as arthritis and that gay, bisexual and other men who have sex with men are at greater risk of being diagnosed with anal cancer or infected with human immunodeficiency virus (HIV) than their heterosexual counterparts. Information on our support for the LBGTQIA2 population is included in Section 2.4.

2. About Your Team

In this section, you are asked to describe the composition of your team, what services you are able to provide, the nature of your working relationships, and the approach you used to develop this submission.

2.1. Who are the members of your proposed Ontario Health Team?

Please complete the tables below identifying the proposed physicians, health care organizations, and other organizations (e.g., social services) that would be members of the proposed Ontario Health Team.

Note:

- In Year 1, Ontario Health Team Candidates will have an agreement in place with the Ministry outlining their responsibilities as a team, including service delivery and performance obligations. Organizations and individuals listed as Ontario Health Team **members** in tables 2.1.1 and 2.1.2 would be party to this agreement and are expected to deliver services as part of their team. If there are organizations who intend to collaborate or be affiliated with the Ontario Health Team in some way but would not be party to an agreement with the Ministry (e.g., they will provide endorsement or advice), **they should be listed in section 2.5**. Note that a Year 1 agreement between an Ontario Health Team Candidate and the Ministry is distinct from any existing accountability agreements or contracts that individual members may have in place.
- *Generally*, physicians, health care organizations, and other organizations should only be **members of one Ontario Health Team**, unless a special circumstance applies (e.g., provincial organizations with local delivery arms, provincial and regional centres, specialist physicians who practice in multiple regions, etc.).

2.1.1. Indicate primary care physician or physician group members

Note: ***If*** your team includes any specialist (i.e., secondary care or GP-focused practice) physicians as **members**, please also list them and their specialty in this table. The information in this table will be used to assess primary care representation and capacity/coverage.

Name of Physician or Physician Group	Practice Model[4]	Number of Physicians	Number of Physician FTEs	Practice Size	Other

[4] Physician practice models include: Solo Fee for Service (Solo FFS), Comprehensive Care Model (CCM), Family Health Group (FHG), Family Health Network (FHN), Family Health Organization (FHO), Blended Salary Model, Rural and Northern Physician Group (RNPG), Alternate Payment Plans. Family Health Teams may also be listed in Table 2.1.1. Community Health Centres, Aboriginal Health Access Centres, Nurse Practitioner Led Clinics, and Nursing Stations should be listed in Table 2.1.2. If you are unsure of where to list an organization, please contact the MOH.

*Provide the name of the participating physician or physician group, **as registered with the Ministry**.* *Mixed or provider-led Family Health Teams and their associated physician practice(s) should be listed separately. Where a Family Health Team is a member but the associated physician practice(s) is/are not, or vice versa, please note this in the table.* *Physician **groups** should only be listed in this column if the entire group is a member. In the case where one or more physician(s) is a member, but the entire*	*Please indicate which practice model the physician(s) work in (see footnote for list of models)*	*For participating physician groups, please indicate the number of physicians who are part of the group*	*For participating physician groups, please indicate the number of physician FTEs*	*For participating physicians, please indicate current practice size (i.e., active patient base); participating physician groups should indicate the practice size for the entire group.*	*If the listed physician or physician group works in a practice model that is not listed, please indicate the model type here.* *Note here if a FHT is a member but not its associated physician practice(s).* *Also note here if a physician practice is a member by not its associated FHT (as applicable).*

group practice is not, then provide the name of the participating physician(s and their associated incorporation name).					
See supplementary Excel spreadsheet					

2.1.2. Indicate member organizations (not including physician(s)/ physician groups)

Name of Organization	Type of Organization[5]	LHIN/Ministry Funding Relationship	Primary contact
Provide the legal name of the member organization		*Does the member organization have an existing contract or accountability agreement with a LHIN, MOH, or other ministry? If so, indicate which*	*Provide the primary contact for the organization (Name, Title, Email, Phone)*
See supplementary Excel spreadsheet			

2.2. How did you identify and decide the members of your team?

Please describe the processes or strategies used to build your team's membership. Are there key members who are missing from your team at this point in time? Are there any challenges your team sees in moving forward with respect to membership?

In your response, please reflect on whether your team is well positioned to care for your Year 1 and maturity populations. Identify any strategic advantages your team has in relation to the health and health care needs of your Year 1 and maturity populations.

Max word count: 500 Overview of the East Toronto Health Partners (ETHP):

[5] Indicate whether the organization is a Health Service Provider as defined under the *Local Health System Integration Act, 2006* (and if so what kind – hospital, long-term care home, etc.), Community Support Service Agency, Service Provider Organization, Public Health Unit, Independent Health Facility, Municipality, Provider of Private Health Care Services, Other: Please specify

Building on a 25-year history of collaboration, in 2017, the CEOs of five organizations representing the continuum of healthcare formed the foundation for an integrated care network (ETHP), and have spent the past two years working with patients, families, community representatives and a range of partner organizations towards this goal.

The newest (sixth) member of the ETHP is the East Toronto Family Practice Network (EasT-FPN), which is described in section 2.9.

The ETHP are committed to a Network of Networks model in which each Anchor partner engages their peer organizations/colleagues with similar service offerings; together we are able to account for the full continuum of care for our attributed population.

Our Membership Model:
The ETHP network of providers serving East Toronto is based on three levels of partnership:

- Members, formal signatories to the Joint Venture agreement and to the eventual accountability agreement with the MOHLTC, which include:
  - Anchor Partners, including the organizational members of ETHP and family physicians represented by EasT-FPN;
  - Patients/Clients, Families and Caregivers;
- Engaged Partners, actively involved in the planning and delivery of specific initiatives; and,
- Supporting Partners, who remain informed and involved, but not active in planning or delivery.

A letter of support from our additional partners is included in the supplemental information attached to this submission. Both our Engaged and Supporting Partners align with our specific Year 1 priority populations and represent the breadth of partnerships required for us to design and implement care transformation. Starting in Year 1, as we start to expand the scope of our integrated care and build towards improving population health for our attributed population, we will evolve our partnership and governance model, including engaging a broader array of health and social service providers. Our Governance approach will enable flexibility for partners to move between levels according to their interests, demonstrated capacity to meet the requirements of their preferred membership level, and organizational circumstances.

Strategic Advantages:
We have identified the following factors that we believe provide us with a strategic advantage in advancing an Ontario Health Team model in East Toronto:

1) The ETHP have a shared vision for ‘A System without Discharges’: A seamless continuum of care focused on population health, with programs tailored to local communities.

2) Our governance approach includes a 'network of network' model in which each of the Anchor Partner organizations engages with their sector of providers across the full continuum of care.
3) Our family physicians have self-organized to form the EasT-FPN, which we believe is the first family practice network of its kind in Ontario.
4) We will be signing a legally-binding Joint Venture agreement between the Anchor Partners in October 2019. The Joint Venture agreement includes our shared principles and how we will work together, as well as with patients, caregivers, and other partners to create an integrated system of care in East Toronto.

The ETHP are confident we are ready to be one of Ontario's first Health Teams.

2.3. Did any of the members of your team also sign on or otherwise make a commitment to work with other teams that submitted a self-assessment?

Team Member	**Other Affiliated Team(s)** *List the other teams that the member has signed on to or agreed to work with*	**Form of affiliation** *Indicate whether the member is a signatory member of the other team(s) or another form of affiliation*	**Reason for affiliation** *Provide a rationale for why the member chose to affiliate itself with multiple teams (e.g., member provides services in multiple regions)*
See supplementary Excel spreadsheet			

2.4. How have the members of your team worked together previously?

Please describe how the members of your team have previously worked **together** in a formal capacity to advance integrated care, shared accountability, value-based health care, or population health (e.g., development of shared clinical pathways or shared patient care, participation in Health Links, Bundled Care, Rural Health Hubs; shared back office, joint procurement; targeted initiatives to improve health on a population-level scale or reducing health disparities).

As part of your response, identify specific initiatives or projects that illustrate the **success** of your teamwork. Include detail about project scale and scope (e.g., patient reach), intended outcomes and results achieved (including metrics), **which** team members were involved, and length of partnership. Note: information provided should be verifiable through documentation by request.

Identify which members of your team have long-standing working relationships, and which relationships are more recent. Also identify whether there are any members of the

team who have ***never*** previously worked with any other members of the team on initiatives related to integrated care, shared accountability, value-based health care, or improvement at the population health level.

Max word count: 2000

Current State:

Building on our long history of collaboration, over the past two years the ETHP has increased the intensity of our work together through a series of tests of change that are designed to advance new models of integrated care delivery, shift more care from hospital to home, and share resources and funding. These tests of change are also referenced in section 5.5, and at a glance they are:

- Home 2Day: Michael Garron Hospital (MGH), WoodGreen and VHA partner to deliver the 'hospital at home' model, delivering seamless transitions and integrated care for COPD patients across hospital and home settings.
- Participation in Bundled Care pathways: MGH and Providence Healthcare (Unity Health Toronto) partner on the Hip and Knee Bundled Care pathway as exclusive partners through a defined MOU, supporting all post-surgical inpatient and day program care for patients. Building on this initial success, other surgical pathways are in development with a focus on reducing total costs, while maintaining patient outcomes and experience. In addition, the Albany Medical Centre is an OHIP funded physiotherapy clinic and has worked on a bundled care basis with the Ministry of Health since 2013.
- Bariatric Centre of Excellence – This is a joint initiative of MGH and Providence to improve care to bariatric patients across East Toronto, including providing local assessment, education and treatment services.
- Community Surge: Starting in 2018, MGH began to reallocate a portion of surge funding to support surge across our community partners, on the basis that seasonal variation in patient volumes is not restricted to acute services and that increased capacity in the community would assist with reducing inpatient and emergency department pressures. This effort included over 10 engaged partners in 2018/19, and expanded to include all 30+ engaged partners in the planning for the 2019/20 surge.
- Health Links: The work of the East and Don Valley Greenwood Health Links brought together local physicians with community providers and hospitals to improve care transitions and access to coordinated care and community services. The Health Links development involved strong community engagement and cross-organizational partnerships around determining the priorities of the Health Links and creating hundreds of care plans.
- SCOPE: Family Practice Physicians in East Toronto have established the SCOPE program with Michael Garron Hospital. SCOPE is a virtual interprofessional health team that supports primary care providers through a single point of access. Family physicians and nurse practitioners registered with SCOPE can connect to local specialists, imaging, and community services, to serve their patients with complex care needs.
- Shared Staffing Resources: In 2019, MGH, WoodGreen and South Riverdale

CHC collaborated on recruitment of a shared Director of Mental Health and Addictions Services. Funding and oversight for this role is shared by the three partner organizations. In addition, in order to support the development of our Ontario Health Team application, different ETHP (Anchor and Engaged) partners contributed in-kind staffing resources to create a 'virtual' project team that provided support for project management, application development and writing, stakeholder engagement, meeting logistics and other aspects of our shared work.

A Long History of Partnership:
East Toronto history of partnership dates back to 1996 when East Metro Health Group (Partners for Health) came together as an incorporated non-profit with its formal partners, Michael Garron Hospital/Toronto East Health Network (then Toronto East General Hospital), South Riverdale Community Health Centre and Public Health. In this time prior to government-mandated networks, the group's visionary goal was to provide the residents of South East Toronto with integrated health services that addressed the determinants of health, population health and community development. By 2001 a voluntary network of healthcare providers known as Solutions – East Toronto's Health Network was created and proved to be the place where real collaboration was taking place. From inception, the Solutions' partnership included anchor ETHP partner organizations along with other community organizations, giving this community an 18-year history of voluntarily working together to address gaps, meet the needs of shared clients and address Provincial health-care priorities. The connection and commitment of all members who contribute equally, trust one another and share similar goals, has been the basis for Solutions' success.
For the past six years Solutions has been co-chaired by Michael Garron Hospital and South Riverdale Community Health Centre; before this by Michael Garron Hospital and VHA Home HealthCare.

Recognizing the need for a legal structure to ensure the new organization's success, East Metro Health Group became a Solutions' member, and has since provided project administration and financial oversight. In 2004 a Procedural Framework was developed to formalize Solutions' governance, membership and operational structure and ensure the accountability of members to one another and to the partnership, as well as a commitment from their senior leaders to this innovative model of voluntary collaboration.
Although much of Solutions' success has been project-focused, its history of working together and developing trust has built a strong basis for shared advocacy and education and led to organizational cohesion and commitment. As a voluntary network, Solutions has also been the venue where inter-organizational relationships have been nurtured so that members can step forward to support one another to ensure that projects beneficial to shared clients across the system are brought to fruition, even those not part of the collaborative. Examples:

- As a group Solutions has advocated against service cutbacks and worked to raise awareness of issues including the challenges of coordinated healthcare delivery. The group has also supported members' endeavours to ensure projects of benefit to the community would be successful, such as supporting South Riverdale Community

Health Centre's quest to become a supervised injection site.

• Solutions became the sponsor for 'Healthy Connections' symposiums for many years. These forums were designed to explore and act on issues of mutual concern about the healthcare system in east Toronto and brought people together for 14 years to brainstorm around topics like health equity, networks and person-centred care. Solutions has many successful projects; several recognized with awards and leading practices. Over its history, members have been funded and supported to work together under the Solutions umbrella on creative projects that benefit clients, the organizations involved and the system at large. Highlights include:

1. MRSA toolkit for community providers: This was developed in collaboration with many community providers including VHA and Michael Garron Hospital (then Toronto East General Hospital). Solutions distributed the toolkit widely across east Toronto to ensure consistency in MRSA communication and treatment across the continuum of care (2002). In addition, for the past year, the Albany Medical Clinic, part of the EasT-FPN has been doing point of care testing for Hep C through their walk-in clinic in partnership with Vircan.

2. Primary Care: Integrating primary care into Solutions' membership and ensuring its representation in projects has been a priority. The South East Toronto Family Health Team and local community health centres have always been members and South Riverdale Community Health Centre a co-chair. In 2003 a Solutions' working group developed a definition of primary health care and completed a literature search on primary care models in urban settings internationally.

3. CREMS (Community Referrals by EMS): This was successfully piloted by Solutions in 2006 and has since expanded to other jurisdictions across the province; 23 by 2015. CREMS, now known as community paramedicine, has improved the response and support available to frequent users of paramedic services by enabling paramedics to perform services previously outside of their jurisdiction, like providing education about chronic disease management or making referrals to community-based support services. The community paramedicine model has improved quality of care for high needs patients and reduced unnecessary emergency room visits and hospital admissions. Interest in the model continues to grow at both the national and international level. The Solutions' CREMS pilot was awarded the first ever Minister's Award in Innovation for Meeting Community Needs through Integrated Care (2007).

4. Back Office Efficiencies and Standardization: An alliance of five Solutions' partners obtained LHIN start-up funding in 2008 to evaluate which back office functions could be effectively shared. A second group, Community Learning in Infection Control (CLIC), was established with Ministry of Health funding in 2011. In collaboration with George Brown College, this group developed e-learning modules to standardize training and develop consistency in infection control practices for front-line providers across the care continuum.

The two groups formally integrated in 2012 to create the Solutions' Learning Management System (LMS) partnership. The partnership provides a cost effective

way to track compliance rates, something that was previously out of reach for most organizations. All LMS partners, whether from the community, long-term care or hospital, have access to standardized online training modules. More recently, wellness and customer service training modules have been developed specifically for the community care environment. Now with 10 member organizations, including ETHP partners Michael Garron Hospital, South East Toronto Family Health Team, South Riverdale CHC, WoodGreen and VHA, the partnership supports more than 10,000 workers across east Toronto.
The LMS hospital-community partnership has been recognized with a best practice from Accreditation Canada for its hand hygiene module developed through CLIC (2011), and a Leading Practice from Accreditation Canada for the LMS partnership (2012).

5. Fostering an LGBTQIA2 Inclusive Environment: Developed in 2015 with five member organizations including ETHP partners Michael Garron Hospital, South Riverdale Community Health Centre and VHA: 1) to build capacity to ensure a welcome environment for LGBTQIA2 patients, and 2) to develop tools and processes to support LGBTQIA2 patients as they transition between member organizations in the hospital and community. Milestones reached:
• A formal partnership agreement with The 519 organization to work towards solving gaps that all organizations have in common.
• Trained over 400 Michael Garron Hospital staff, 825 VHA Home HealthCare staff, 200 South Riverdale CHC clinicians and 100 volunteers and Board members, as well as staff from other Solutions' partner organizations to ensure a journey that is therapeutic, patient centered and inclusive across the care continuum.
• Completed a needs assessment to identify gaps and, with the 519, developed resources to address the gaps identified, e.g. inclusive language in policies. One of the key outcomes currently underway is the development of a LGBTQIA2 Inclusion Playbook for Healthcare, reflecting diverse settings and demographics in case studies that map effective, evidence-based strategies to enhance LGBTQIA2 patient experience and health outcomes.
• Created a google share page where partners can learn and share with one another.

6. Kids Grow SLP Project: A project to enhance the effectiveness and access to community-based Speech Language Pathologist (SLP) Services for children in Thorncliffe Park who are unable to access the SLP services they need.
The project is designed to embed speech and language therapeutic interventions in Health Access Thorncliffe Park's primary care delivery model with close linkages to the community and locations within the school, mall and the local Ontario Early Learning Years Center. The goal is to deliver service is in an environment the children are familiar with, eliminate the transportation challenges faced by many families in this community and decrease wait times for the existing school-based SLP services. Positive outcomes may make a case for government-funded community-embedded SLPs as part of a comprehensive community care team. The project is currently underway with partners Michael Garron Hospital, Health Access Thorncliffe Park and Thorncliffe Neighbourhood Organization, to be evaluated in late 2019.

7. Peer Outreach Point-of Care Testing as a Bridge to Hep C Care: A partnership of Michael Garron Hospital and South Riverdale Community Health Centre, this project is evaluating the use of point-of-care Hep C Viral tests (providing HCV antibody results within 30 minutes and requiring only pin prick blood samples) by peer outreach workers to see if it will further improve client engagement in Hep C care beyond peer outreach alone. The project is currently underway, and outcomes are not yet available.

In addition to the collective work of the Solutions network, we have many other local partnerships including the following examples:

o WoodGreen and South Riverdale CHC (SRCHC) have delivered integrated mental health and addictions programs for several years and have worked together on many strategic initiatives and joint ventures. SRCHC has provided a number of clinical services to WoodGreen's clients across several programs, including harm reduction services, medical care, nursing services and flu clinics. These integrated care models have focused primarily on improving the network of services in the East for seniors who are vulnerable, homeless or precariously housed, experiencing addictions or in crisis. The partnership grew out of an identified need for better leveraging of local health resources, and one example of the success we have seen is through the Seniors Crisis Initiative Service model, in which SRCHC clinical staff and WoodGreen social work staff conduct joint mobile crisis visits, care planning, case conferencing and follow-up. Through this model we are able to divert ED visits for non-medical crises by supporting seniors living in the community.

o VHA and WoodGreen partnered to enhance and maintain member participation in WoodGreen's Adult Day Programs. Working with program staff and family caregivers, VHA has provided an Occupational Therapist to provide consultation and behaviour management techniques for those members with declining cognitive health.

2.5. How well does your team's membership align to patient/provider referral networks?

Based on analysis of patient flow patterns and the natural connections between providers and patients revealed through this analysis, your team has been provided with information about which patient/provider referral networks the physician and hospital members of your team are part of.

How would you rate the degree of alignment between your current membership and the

provider networks revealed through analysis of patient flow and care patterns (high, moderate, low)? Where alignment is moderate or low, please explain why your team membership may have differed. Given the provided data, have you updated your team membership since the Self-Assessment?

Max word count: 500

The ETHP provides high alignment between the current membership and provider networks, and the partners have an approach in place to achieve full alignment at maturity. Our 'network of networks' governance model means that each of the Anchor Partner organizations connects with a sector of providers including; hospitals/acute care settings, rehabilitation and long-term care facilities, community health centres, community mental health programs, home healthcare agencies, family practice physicians, other primary care providers, and community support agencies. In addition, through our engaged and supporting partners, we have collaborations that include other organizations serving our specific Year 1 populations.

The ETHP have established relationships with tertiary and quaternary partners to support patient access for specialized care. Examples include defined partnerships and close clinical integration with Sunnybrook Health Sciences Centre for adult care needs, and with Sick Kids and Holland Bloorview for specialized children's health and developmental care. In addition, in February 2019, we launched SCOPE, a partnership between family physicians and hospital-based and community-based resources that provides a virtual interdisciplinary team for family practice. Close partnerships with midwifery providers, Toronto Public Health and Toronto EMS also provide supporting wraparound care for the needs of our community, delivering upstream preventative care and health promotion, and emergent assessment and transfer services. Finally, as part of our commitment to priority neighbourhood planning, we also formed partnerships with broader community agencies and various local neighbourhood leaders to leverage community social services and volunteer organizations that reflect our diverse local populations, such as community settlement programs.

The only addition to our members since the self-assessment is the East Toronto Family Practice Network (EasT-FPN), which, as described in section 2.9, was created to be the unifying voice of family physicians in East Toronto. Prior to the formation of the EasT-FPN, primary care was represented by a physician lead role supported by the TC LHIN. And as described in section 4.2, a Patient and Caregiver Engagement Planning Team consisting of advisors from existing Patient and Family Advisory Committees from the different Anchor Partners and the Toronto Central LHIN was established to advise on different approaches to patient, family, caregiver and community engagement including overall governance for the ETHP. Our Patient and Caregiver Engagement Planning Team is assisting us with next steps in this work, including identifying ongoing membership at the governance level.

At maturity, all health service providers and family practice physicians will be linked to

the ETHP.

2.6. Who else will you collaborate with?

Please provide information on who else your team plans to collaborate or affiliate with. Describe the nature of your collaboration and include information on any plans to coordinate services with these providers or organizations. If your team has received endorsement from specialist physicians or clinical leaders/leadership structures (e.g., Chiefs of Service, Medical Directors, Medical Advisory Committees), please list them in table 2.6.1.

2.6.1. Collaborating Physicians

Name of Physician or Physician Group	Practice Model	Number of Physicians	Collaboration Objectives and Status of Collaboration
			Describe your team's collaboration objective (e.g., eventual partnership as part of team) and status (e.g., in discussion)
See supplementary Excel spreadsheet			

2.6.2. Other Collaborating Organizations

Name of Non-Member Organization(s)	Type of Organization	Collaboration Objectives and Status of Collaboration
Provide the legal name of the collaborating organization	*Describe what services they provide*	*Describe your team's collaboration objective (e.g., eventual partnership as part of team) and status (e.g., in discussion)*
See supplementary Excel spreadsheet		

2.7. What is your team's integrated care delivery capacity in Year 1?

Indicate what proportion of your Year 1 target population you expect to receive **integrated care (i.e., care that is fully and actively coordinated across the services that your team provides)** from your team in Year 1. Please provide a rationale for this estimate and describe what actions you will take to ensure as many Year 1 patients who require integrated care will receive it.

Max word count: 500 Through our members and the scope of services we provide, ETHP will make integrated care available for patients, caregivers and families within the priority

populations to the greatest degree possible in Year 1. Our Family Practice Network will take a leadership role in working with Year 1 populations and connecting their patients to actively coordinated care. Seniors and Caregivers with Chronic Care Needs who are admitted at Michael Garron Hospital will benefit from new integrated approaches to ensure effective transitions from hospital to home. We will also continue providing our current services to the priority populations and all those seeking care in East Toronto.

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Because our Networks (in the Network-of-Networks model) are still growing and expanding, we may not be able to proactively reach all members of our priority populations in Year 1. Currently, 25-35% of acute care for our attributed populations occurs outside of our ETHP hospitals. We recognize the impact of patient choice on our ability to interact with our attributed population and through our previous experiences we know that it takes time to build trust and relationships across our communities and residents as we deliver care in new ways. The ETHP also acknowledge that there are resource restraints affecting our ability to provide fully integrated care for all populations; for example there are limitations in availability of long-term care spaces, supportive housing, and many community services at the present time. Increases in capacity are important for providing fully integrated care for all priority populations.

Of our total attributed population of 375,000, the 178 family practice physicians who have joined the new East Toronto Family Practice Network (EasT-FPN) care for approximately 200,000 patients. In addition, the priority populations for Year 1 aggregate to roughly 69,000 people.

- All of the 53,712 seniors within the attributed population
- All of the 7,288 individuals with a diagnosis of Alcohol or Drug Dependency
- A total of 7,977 youth living with mental health conditions (estimated 20% of the attributed population aged 15-24)

Through our partners and the scope of services we provide, ETHP will provide actively coordinated care for roughly 20% of the total Year 1 population: a total of 13,800 individuals. In addition, the 200,000 residents who access primary care through family physicians who are part of EasT-FPN will have access to integrated care through our SCOPE program, interprofessional care teams, fall/winter community surge investments and other existing programs in East Toronto.

2.8. What services does your team intend to provide in Year 1?

Provide a description of each service, indicate whether the service would be available to your entire Year 1 population or a subset (with rationale), and indicate which member of your team will provide the service.

Ontario Health Teams
Full Application Form

Service	**Proposed for Year 1** (Yes/No)	**Capacity in Year 1** (how many patients can your team currently serve?)	**Predicted Demand in Year 1** (of your Year 1 population, how many patients are predicted to need this service)	**Description** (Indicate which member(s) of your team will provide the service. If a proposed service offering differs from your team's existing service scope, please provide an explanation as to how you will resource the new service. If there is a gap between capacity and predicted demand, identify if you have a plan for closing the gap.)
See supplementary Excel spreadsheet				
Interprofessional team-based primary care				
Physician primary care				
Acute care – inpatient				
Acute care-. ambulatory				
Home care				*Please complete Appendix A.*
Community support services				
Mental health and addictions				
Long-term care homes				
Other residential care				
Hospital-based rehabilitation and complex care				
Community-based rehabilitation				
Short-term transitional care				
Palliative care (including hospice)				
Emergency health services (including paramedic)				
Laboratory and diagnostic services				
Midwifery services				

Health promotion and disease prevention				
Other social and community services (including municipal services)				
Other health services (please list)				

2.9. How will you expand your membership and services over time?

At maturity, Ontario Health Teams are responsible for offering a full and coordinated continuum of care. Teams are expected to expand the population they serve each year, working towards providing care for their entire attributed population.

Describe your plan for phasing in the remaining continuum of care for your population, including proposed timelines. Your plan should include explicit identification of further members, collaborators, and services for inclusion for Year 2. Include in your response commentary on whether your team anticipates any challenges in expanding the types of services your team provides or meeting demand for services beyond year 2, given your attributed population.

Max word count: 500

The ETHP understand that designing and delivering a full population-based model of care will take several years. In Year 1, we will work with partner organizations and engage our whole community in a process of visioning and developing strategic priorities that will move us toward designing a full continuum of care centered on improving overall population health (see section 6.1 for more details). At the same time, we will initiate planning and design of improvements for our specific Year 2 populations, with our Engaged partners and others who are critical supports.

Our Year 2 populations include palliative/end-of-life care and perinatal care. Per our self-assessment, we included advanced care planning and palliative/end-of-life care as a natural and important extension of the continuum of care for our Year 1 population of seniors with chronic disease and caregivers. Through Health Links, across the intersectoral partners and including patients, we have developed tools and a common language to educate patients and families about Advanced Care Planning using a consistent approach (https://www.advancecareplanning.ca/across-canada/launch-of-advance-care-planning-e-learning-modules/). Physician members of the EasT-FPN (SETFHT), MGH and TC-LHIN home care have built a strong partnership through the Virtual Ward and SETFHTHomevisit Program to identify frail homebound seniors without a home visiting doctor and provide them integrated care including end of life and home-palliative care.

Palliative care represents our highest average cost per patient, more than 5% of total health care expenditures in East Toronto, and acute palliative represents our second most costly HPG (Source: MOHLTC East Toronto data package Aug. 2019). Over the next year we will engage with partners across acute, community, and primary care, as well as with caregivers to prioritize opportunities to develop expanded integrated palliative and end-of-life care in our local area that also connects with regional programs and supports for this population.

Perinatal care was chosen as a Year 2 population because of our priority neighbourhoods, including Thorncliffe Park which has the highest birthrate in the City of Toronto, and one of the highest birthrates of any community in Canada with average birthrates of 85/1000 women as compared to the Toronto average of 42/1000 (Source: Toronto Public Health). Michael Garron Hospital delivers roughly 2,500 babies per year through both its obstetrics and midwifery programs. The Midwifery program is well-established at Michael Garron Hospital in partnership with The Midwives Clinic of East York/Don Mils and a long-standing relationship with South Riverdale CHC for referrals and access for uninsured patients. The midwives, family physicians of the EasT-FPN (SETFHT) with obstetrical expertise, and the MGH obstetrics department started outreach into Thorncliffe Park to provide obstetrical care on site, and this initiative now has been integrated into the Health Access Thorncliffe Park community hub.

Beyond our Year 1 and 2 populations, we will continue to deliver the current broad range of health services to our attributed population. In consultation with community members and providers across East Toronto, we will continue to evolve our planning for targeted services and population health needs beyond Years 1 and 2.

If you do not have all primary care providers in your network involved at this point, please describe what efforts have been made to date to involve these providers and your plan for how you will expand primary care partnerships to meet population need at maturity.

Max word count: 500

The East Toronto Family Practice Network (EasT-FPN) was established in September 2019 as a not-for-profit corporation with an interim skills-based board of 14 directors, the majority of whom are family physicians practicing in East Toronto. Prior to the formation of the EasT-FPN, primary care physicians were represented by a physician lead role supported by the TC LHIN.

The EasT-FPN was created to be the representative voice of family practice within the ETHP Ontario Health Team. The physicians on the Board represent all family practice models that exist in East Toronto. The goal for EasT-FPN is to become a network that represents all 260 family physicians in East Toronto; solo practitioners and physicians who are part of a Family Health Group (FHG), Family Health Organization (FHO),

Family Health Team (FHT) or Community Health Centre (CHC). As of October 2019, the EasT-FPN serves as a full anchor partner in the ETHP group; with the vision to be the go-to voice for primary care in East Toronto.

The EasT-FPN together with MGH has initiated a series of combined education and engagement sessions for family physicians about our OHT, with the first event held in mid-September 2019. The first session 'Working Better Together for Our Patients' included updates regarding the Ontario Health Team and the emerging Family Practice Network. There is a long tradition of close working relationships between local family physicians and hospital specialists, and these well attended events are held regularly. The EasT-FPN will engage actively with the MGH specialists in order to explore opportunities for better and more efficient care between family physicians and specialists within a future integrated care system, and with an understanding that there are specialties that contribute significantly to quality primary care.

The EasT-FPN website has launched (eastfpn.org) and it contains a Road Map and timelines for building out the Network and registering members. Key activities planned over the next six months include 1) Expansion of membership through in-person and virtual town halls open to all family practice clinicians, 2) Drafting bylaws and other documentation formalizing the role of the EasT-FPN, and 3) Proposing and negotiating funding agreements with Ontario Health and the MoHLTC strengthen the EasT-FPN in participating a a strong primary care partner in the OHT.

At the present time EasT-FPN has the support of 178 family physicians serving the needs of almost 200,000 patients in East Toronto. Plans for ongoing recruitment for all 260 family physicians are in place.

Across Ontario, this is the first such emerging formally organized network that captures the interests of previously unaffiliated family physicians, a particular challenge for the city of Toronto. As an Anchor Partner to the East Toronto Health Partners, the EasT-FPN primary care network will solicit regular input from all local primary care practitioners as we work to transform and provide leadership towards the OHT design and the implementation of an integrated system of care.

2.10. How did you develop your Full Application submission?

Describe the process you used to develop this submission. Indicate whether it was an participatory process across all members and if your submission reflects a consensus across the entire membership. If so, describe how consensus was achieved. Indicate whether any third parties external to your team were involved in the completion of this form (e.g., grant writers, consultants).

Also consider in your response:

- If patients, families, and caregivers partnered or were engaged or consulted in the design and planning of this submission, please describe any partnership,

engagement, or consultation activities that took place and whether/how feedback was incorporated.

- If your team engaged with the local community in the design and planning of this submission, please describe any engagement activities that took place and whether and how feedback was incorporated. In particular, please indicate whether your team engaged with local Francophone communities (e.g., local French Language Planning Entities) or with Indigenous communities. Describe the nature of any engagement activities with these communities and whether/how feedback was incorporated.
- If you have community support for this application (e.g., support from a municipality), please provide a description and evidence of this support. If your team's attributed population/network map overlaps with one or more First Nation communities [https://www.ontario.ca/page/ontario-first-nations-maps], then support from those communities for your team's application is required. Where applicable, please indicate whether you have support from First Nation communities. Indicate the nature of the support (e.g., letter of support, band council resolution, etc.). If you do not have support at this time, provide detail on what steps your team is taking to work together with First Nations communities towards common purpose.

Max word count: 1000

As described in section 2.4, providers in East Toronto have a long history of partnering to improve health care. In 2017, prior to the policy direction for Ontario Health Teams, the ETHP was formed with a specific vision to accelerate the integration of health and social care in East Toronto, co-designed with patients and caregivers. When the call for proposals for OHTs was announced, we were able to leverage the work we had already started to support our self-assessment and this application.

Application Development:
Our full OHT application was generated with full participation from the Anchor Partners. Different sections of the application were assigned to different "lead" writers from across the Anchor Partners, who generated the content as informed by our working groups, which include participation from providers, patients and caregivers. No external consultants or writers were involved with this application. Several drafts of the application were reviewed and edited by the Anchor Partner organizations. Patients and Caregivers from our Engagement Planning Team (described below) were asked to review sections of our draft document and provide feedback, with a particular focus on content related to patient and caregiver engagement and supports. The application represents a consensus from the ETHP Anchor Partners, which have signed off on the final version.

Patient and Caregiver Engagement:

Since our inception, ETHP leaders have engaged patients and community in our work to co-design more integrated systems of care. The inaugural leadership table included two community members to inform our vision, guiding principles, and goals. Each of our priority population workstreams as well as our home care redesign sessions and digital health teams have included patients, caregivers and family members as contributors to the design of the future state.

After completing our self-assessment, the ETHP made a decision to pause our existing approach to 'inviting' patients and caregivers to different planning tables, and instead decided to ask patients and caregivers how they would like us to engage them in the next phase of our OHT work. We asked members of Patient and Family Advisory Committees from different East Toronto provider organizations to participate in 'Engagement Planning' with us. In August and September, we hosted two meetings of this group and asked for their advice on different approaches to patient, family, caregiver and community engagement going forward.

As a next step in our partnership with patients and caregivers, our Patient and Caregiver Engagement Planning Team has recommended that the ETHP establish a joint Patient and Family/Caregiver Advisory Committee (PFAC) to support the work of the ETHP and that the joint PFAC will further recommend a process for including patient/caregiver representation for the ETHP Governance. These and other recommendations are detailed in section 4.2.

Stakeholder and Community Engagement:
Since the readiness application was submitted, the Anchor Partners have continued with consistent communication across participating organizations: the CEOs meet weekly, as do our senior team members, communications departments and digital health leaders; and our priority population work groups with additional stakeholders meet at least monthly to improve care design. Each of our work streams includes patient/caregiver advisors as well as representatives from the relevant community organizations aligned with the priority populations.

ETHP has developed a Community Engagement Framework with patient representatives as partners. The Framework is a best practice guideline for current and future engagement activities within the OHT planning context, and reflects unique contributions and perspectives of patients, community members and providers. Patient representatives were engaged in a joint working group with representation from the East and Downtown East OHTs. This framework will be the foundation for our ongoing engagement activities.

In September 2019, the Anchor Partners hosted a community webinar to share progress on our OHT development with the community and partner organizations, answer questions, and share opportunities for ongoing engagement with our community.

Engagement with the Francophone Community:

The East Toronto Health Partners has been working in close collaboration with Reflet Salvéo, one of Ontario's six French Language Health Planning Entities, Fondation Hélène Tremblay Lavoie Foundation, as well as with its Francophone community. ETHP leveraged the results from multiple surveys conducted by Reflet Salvéo over the last years to gauge the needs of their Francophone community. The data and information gathered from these engagements have confirmed the multiple issues faced by Francophones in determining the Year 1 population needs, specifically for Francophone seniors with chronic disease and caregivers and those living with mental health & addictions.

The ETHP has also partnered with Les Centres d'Accueil Héritage on the Leadership Training on Active Offer with an ETHP education session in mid-September 2019, to gain a greater understanding of the importance of French Language Health Services as part of the Ministry's transformational agenda, which is to provide a connected health care system centred around patients, families and caregivers, including Francophones. A letter of support from Les Centres d'Accueil Héritage is included with our application submission.

Engagement with Indigenous Communities:
Although the East Toronto Health Partner geography does not overlap with a specific First Nations Community, each of the Anchor Partners has existing avenues for engagement with local Indigenous communities. For example, both South Riverdale CHC and Michael Garron Hospital work with indigenous Elders who are advisors for care design and delivery of culturally appropriate services. VHA Home HealthCare has an Indigenous member on their Advisory Council. Michael Garron Hospital has co-designed several programs with Indigenous Communities including an Aboriginal Healing Program for Withdrawal Management. In August 2019, members of the Aboriginal Healing Program and members of the Toronto East Health Network celebrated the opening of a Sweat Lodge on the hospital grounds. In early September, the ETHP met with the Unity Health First Nations, Inuit, Metis and Indigenous Community Advisory Panel to ask their advice on our approach to Indigenous community engagement.

The ETHP has also requested a meeting with Anishnawbe Health Toronto to learn more about their models for community engagement. The ETHP is committed supporting the rights of our indigenous communities to self-determine how they will engage with the OHT work.

3. How will you transform care?

In this section, you are asked to propose what your team will do differently.

By redesigning care for their patients, Ontario Health Teams are intended to improve patient and population health outcomes; patient, family, and caregiver experience; provider experience; and value. By working together as an integrated team, Ontario

Health Teams are also expected to help improve performance on a number of important health system measures, including:

a) Number of people in hallway health care beds
b) Percentage of Ontarians who had a virtual health care encounter in the last 12 months
c) Percentage of Ontarians who digitally accessed their health information in the last 12 months
d) 30-day inpatient readmission rate
e) Rate of hospitalization for ambulatory care sensitive conditions
f) Alternate level of care (ALC rate)
g) Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
h) Total health care expenditures
i) *Patient Reported Experience Measures, Provider Reported Experience Measures, and Patient Reported Outcome Measures are also under development*
j) Timely access to primary care
k) Wait time for first home care service from community
l) Frequent ED visits (4+ per year) for mental health and addictions
m) Time to inpatient bed
n) ED physician initial assessment
o) Median time to long-term care placement
p) 7-day physician follow up post-discharge
q) Hospital stay extended because the right home care services not ready
r) Caregiver distress

This is a non-exhaustive list of metrics that reflect integrated care delivery systems.

3.1. What opportunities exist for your team to improve care for your population and health system performance in Year 1 and at maturity?

Considering the measures listed above and the health status of your Year 1 and maturity populations, please identify and provide rationale for what your team considers to be your **most important (e.g., top three to five) performance improvement opportunities** both for Year 1 and longer term. In your response, consider your team's assets, the services you intend to provide, and the features of your Year 1 and attributed populations. Explain how you identified these priority improvement opportunities and any relevant baseline performance data you have for your Year 1 and/or attributed populations.

Max word count: 1000

The ETHP see significant opportunities to improve care for our population and health system performance as we advance our efforts to create an integrated health system for our attributed population. Our shared vision is centred on creating 'a system without discharges'; one connected system of health care and support for all residents in East Toronto. Our most important improvement opportunities are fully aligned to

this shared vision:

1) Create a one-team approach with patients, caregivers and providers: This includes engaging with care recipients to design care transformations that meet their needs, supporting our staff to work to their full scope, and building stronger networks between providers who deliver similar and complementary services. For our Year 1 focus, we will expand our integrated, interprofessional team-based care models and connect and simplify access for community support services. We will also connect health promotion, health education and self-management support – through home visits, virtual tools, and expansion of existing peer led support groups. For our youth and adults with mental health needs, our focus will be on building skills, relationships and trust, to support them with their goals.

2) Coordinated Care tailored to Local Neighbourhoods; scaling up our early successes: This includes evaluating and expanding our existing integrated care initiatives to include more partners, improve care delivery for larger numbers of patients and caregivers, and shift more care from hospital to community. We will co-design tailored solutions for our 21 neighbourhoods to address their distinctive needs, ranging from designated improvement areas to higher income communities. For our Year 1 focus, we are targeting improvements to three Neighbourhood Improvement Areas as defined by the City of Toronto; Thorncliffe Park, Taylor-Massey and Oakridge – we are advancing a 'one team' approach by integrating inter-organizational, inter-professional teams that act as single team working together to support local residents. We will also expand our Home 2Day program to support a broader range of patients with cardiac and respiratory conditions, increase our community surge investments, and expand our interprofessional care team models to other neighbourhoods in partnership with primary care partners.

3) Support the Success of our New Family Practice Network – The ETHP is very excited to welcome our newest member, the East Toronto Family Practice Network (EasT-FPN) which is described in section 2.9. Full engagement of primary care at every level of the ETHP is critical to the success of an integrated model of care in East Toronto. The existing Anchor Partners will work closely with the EasT-FPN to ensure that we have multiple ways to engage family physicians, as well as clear, open two-way communications about the ongoing work of the ETHP, including the value for family physicians across our community to be part of the design and evolution of the ETHP. While the EasT-FPN is early in its development, they are already identifying opportunities to improve care in East Toronto. We have also committed to collaborating on a financial plan to support the ongoing work of the ETHP.

4) Streamline Access and Navigation, enabled by Digital and Virtual Care: This includes providing easier access to information and access to services, reducing the burden of chronic disease, and improving coordination of care to support patients and their caregivers. For our Year 1 focus, we will: finalize our asset maps of services that support our Year 1 populations; implement digital navigation tools that help patients access local services such as those for Youth mental health and wellness; and,

establish patient navigators to provide seniors with chronic disease and caregivers with health system navigation, support service planning, care plan accountability, support clients from hospital into community. For individuals who access the Emergency Department related to substance use we will coordinate access to community services based on similar models implemented at peer hospitals. The addition of our EasT-FPN Anchor Partner will also enable us to further understand the extent of electronic medical records currently in use by local family physicians.

5) Improve population health and health equity: This includes reducing gaps in care and improving coordination of services for vulnerable, marginalized and under-served populations. For our Year 1 focus, we are targeting improvements for seniors living in Toronto Community Housing buildings, youth with mental health concerns, and adults with substance use issues.

These improvement opportunities were identified from the data for our attributed populations and our Year 1 priority populations, including:

Seniors with Chronic Disease and Caregivers
o Within East Toronto's attributed population, 53,712 (14.3%) are seniors aged 65+ and 23,122 are seniors aged 75+
o In 15 of 21 neighbourhoods in East Toronto, more than half of seniors (age 65 and over) are living with 4+ Chronic Conditions as compared to the City of Toronto average of 47%
o Eighteen of 21 neighbourhoods in East Toronto have COPD rates above the City of Toronto rate.
o Annually, 9,000 individuals living in East Toronto receive home care services, most of whom are seniors living with one or more chronic diseases.
o Data show high caregiver distress (38.9% of Toronto Home and Community Care Clients reporting Caregiver Distress); rates of caregiver distress have increased annually for the last 5 years
o Many neighbourhoods have a high rate of seniors living alone; e.g. 40.7% in Thorncliffe Park, and 41.8% in East End-Danforth

Substance Use and Health
o The prevalence of mental health and substance use problems in Toronto East is 10.2 per 100, which is higher than the rate for the Toronto Central LHIN.
o Michael Garron Hospital sees over 600 women annually who present to the ED with substance use related issues and there are currently no detox beds for women in East Toronto.
o Repeat ED visits for mental health and substance use is high, with limited sustained connectivity to community mental health and substance use services.

Youth Mental Health and Wellness
o Youth represent 23.1% of the population in Toronto East – the highest proportion in the Toronto Central LHIN.
o ED utilization for youth from the Taylor-Massey neighbourhood is three times higher

than comparable data for other areas in the Toronto Central LHIN.
o There is a higher prevalence of mental health, substance use, trauma among immigrant, ethno-cultural, racialized and refugee communities. Minorities represent 43% of East Toronto's population (vs. TC LHIN 35%), and East Toronto has the highest proportion of recent immigrants in the TC LHIN.

3.2. How do you plan to redesign care and change practice?

Members of an Ontario Health Team are expected to **actively work <u>together</u>** to improve care for their patients. Please describe how you will work together to redesign care and change current practices in your first 12 months of operations to address the performance improvement opportunities you identified in section 3.1.

In your response, please consider what specific outcomes you're aiming to achieve, as measured by one or more of the indicators listed above (or others, as relevant), and what targets, if any, you have set from baseline.

Note that detailed commentary on how you propose to provide care coordination and system navigation services, virtual care, and patient self-management are requested in subsequent sections.

Max word count: 2000

As described in section 2.4, our collaboration to improve care in East Toronto started over 20 years ago with the launch of partnerships to provide better care to the residents of South East Toronto; the foundation for the ETHP. Over the last 18-24 months, the ETHP has hosted a number of community engagements designed to advance a network of care and identify priority populations for care improvements. In Spring 2019, design workshops were held with partners, patients and caregivers, to identify a vision and approach to care transformation for our priority populations. We established the following set of shared principles for redesigning care and changing practice:

1. Everyone will know how to access and navigate health care in East Toronto
2. Every person will have timely access to culturally competent primary and inter-professional care when needed
3. Communities will have access to inter-professional care teams with dedicated coordination for complex care needs
4. Every health care provider will be connected as part of one system of care, including primary care and links to existing EMRs
5. Our leadership and governance model will reflect shared accountability and collaboration across primary care, community-based care and hospital care
6. Performance measures will: reflect population health outcomes and equity; reflect patient and community experience; track value; and, be transparent and public.
7. Providers will be jointly committed to continuous improvement and connecting with social services, including; innovating and activating digital enablement of care delivery, establishing a collaborative Quality Improvement Plan and, engaging

partners to improving care across the social determinants of health
8. Investment will be targeted to meeting local need and the costs of delivering care will be lowered while keeping the quality of care high.

Following our initial design work and building on a number of ETHP initiatives already underway, our work in Year 1 is described below.

Seniors with Chronic Disease and Caregivers:
The following key initiatives were identified and prioritized for the Year 1 implementation of improved care for this population:

• For seniors with complex or rising risk/needs, we will establish patient navigators using existing staffing resources in East Toronto, to provide patients with health system navigation, support service planning, care plan accountability, and one touchpoint following the client from hospital into the community,
•For seniors with low to medium risk/needs, primary care providers will work with other health care and community providers in integrated community hubs to support chronic disease self-management and well-being for seniors; the EasT-FPN has endorsed the “Patient-centred medical home model” as a model for chronic disease care
• Advance a technology architecture and priority digital solutions to connect, collaborate and communicate amongst providers, primary care and with patients and caregivers
• Expand the Home 2Day Program to provide flexible bundled care – and extend this program to include patients with other cardio/respiratory conditions
• For seniors living in Toronto Community Housing (TCHC), the ETHP have partnered with the City of Toronto to implement phase one of the Integrated Service Model for Seniors Buildings in 18 local seniors’ buildings. This increase access to primary care and community services, streamline health and social service navigation via a single care coordinator serving each building, and link housing staff and service providers with a one-team approach. We are fortunate to have an existing model of a full integrated primary care and interprofessional team in several TCHC housing sites in Oakridge and Warden Woods, which we can learn from to expand this model of care.
• For seniors living in the community we will simplify access to key community programs and hospital services by establishing centralized referral and intake processes and implementing quality standards for all East Toronto CSS agencies providing meals-on-wheels, congregate dining, adult day programs and case management.
• Organize and connect health promotion, health education and self-management support – through home visits, virtual tools, expansion of existing peer led support groups

Our work in Year 1 to improve care for seniors with chronic diseases and their caregivers is designed to improve the following outcomes:

1. Improved access to appropriate care:

o Reduced emergency department visits among seniors living in social housing
o More timely access to primary care (Baseline: 42% of patients able to book same day/next day appointment when sick, average across Q1-Q4 of 17/18)
o Increased % of seniors that have access to inter-professional primary care team (NCTs, physicians, CHCs)
o Increased number of seniors attached to a navigator, health coach, or care coordinator

2. Reduced Caregiver distress:
o (Baseline: 38.9% of home care clients)

3. Improved Patient Experience: Patient experience measurement will focus on care coordination and delivery of integrated care

4. Improved provider experience: Provider experience measurement will focus on experience with partnerships and coordination of care

Substance Use and Health:
The following key initiatives were prioritized for Year 1 implementation of improved care for this population:
• Introduction of a Substance Use and Health Hub in the East Danforth Area to serve the approximately 13,505 people living in the Oakridge neighbourhood (StatCan 2011). Oakridge is a neighbourhood with low availability of services and supports for substance use. This hub will provide a full continuum of services for those managing substance use disorder as well as health promotion and preventative care. To deliver these services, partners are developing an agreement to co-locate services and participate in planning, implementation and evaluation of this initiative.
• Address the service gap for women's detox and utilize opportunities for providers to collaborate around service pathways and improvement of coordination of services. Opening 8 women's withdrawal management beds by repurposing underutilized beds for men and improving care pathways with community partners who serve women with substance use disorders.
• Improve connectivity between ED and community services. Exploring a partnership to embed community mental health staff in the MGH ED to facilitate a warm transition to community services; similar to other at peer hospitals in the GTA, where evaluation showed that frequent users of the ED had up to a 60% reduction in repeat ED visits for substance use.

Our work in Year 1 is designed to improve the following outcomes:

• Reducing ED visits for residents of Oakridge: In 2016, it was estimated that 6,372 visits to Michael Garron Hospital's Emergency Department came from Oakridge. It has the highest rate of hospitalizations and lower primary care continuity relative to other East Toronto neighbourhoods. Residents of Oakridge are disproportionately represented among Emergency Department visits at MGH for substance use and utilize high numbers of harm reduction kits (source: South Riverdale CHC).

• Improving access to withdrawal management services for women: At the present time there are no crisis beds for withdrawal management services for women in East Toronto. As a result, women requiring this support either stay in the MGH ED or have to travel to West Toronto for care. We are also working with Toronto Paramedic Services to include withdrawal management services as one of the non-traditional destinations for the new ambulance service model, to better align resources to patient needs, and reduce the burden on limited ED capacity.

Youth Mental Health and Wellness:
The following key initiatives were identified and prioritized for the Year 1 implementation of the future state model for this population:
• The Youth Wellness Hub opened in East Toronto in summer 2019: a multiservice health and social centre co-designed with local youth and co-delivered with multiple partners. In Year 1 we will evaluate its success and seek opportunities to spread and scale this model to other high need areas in East Toronto.
• In July 2019 we hosted an asset mapping workshop that engaged 20 local youth and 30 providers. We sought to understand which mental health resources would be valuable for youth, and how they would like to find out about those resources. Building on the results from this workshop, we will help youth identify a digital solution to help them better understand what local mental health assets are available to them.
• We will leverage our digital strategy to enable access to 24/7 support for mental health and addictions issues for youth.
• We will engage with immigrant, refugee, ethno-cultural and racialized youth to develop an understanding of their needs and how best to serve them to optimize their mental health.
• The ETHP are partnering with Toronto-based Mental Health T.O. (MHTO), which connects young people and their families to publicly funded core mental health services. In Year 1, in collaboration with local core service providers, MHTO will incorporate full intake procedures and assessments as well as service navigation roles. MHTO will incorporate full intake processes and assessments as well as service navigation roles

Our overall goal for our youth mental health work is to build relationships and common understanding of resources, and to listen to youth voices as we reimagine care to better support them. Our work in Year 1 is designed to improve the following outcomes:

1. Improved access to supports and services:
o navigation, intake to mental health services for youth and improved coordination between them (increased availability to 24/7, increased # accessing service)
o culturally competent and sensitive mental health and wellness services for youth.
o digital mental health solutions
2. Reducing ED visits for youth

Additional Care Transformation to support Year 1 Priority Populations

• 24/7 Crisis Support: ETHP will expand the populations served by the Toronto Seniors Helpline to include youth, families and adults, introducing a new integrated platform for online referrals, and maintaining the highly effective mobile crisis service for seniors, which diverts seniors from the ED. The Seniors Crisis Services Initiative (SCSI) targets seniors (65+) and older adults (55+, depending on severity) living at home with suspected or diagnosed mental health and/or substance use issues, cognitive impairment, dementia, responsive behaviours, chronic health concerns or geriatric challenges; and also provides supports for their families and caregivers. SCSI integrates access to existing resources at WoodGreen, LOFT and Reconnect, and leverages partnerships with the Crisis Outreach Service for Seniors (COSS) program, Toronto Central LHIN Home & Community (formerly CCAC), Baycrest Behavioural Supports for Seniors, Gerstein Crisis Centre, South Riverdale Community Health Centre, 310-Cope, Scarborough Hospital Mobile Crisis Program, Toronto Police Mobile Crisis Intervention Teams, Community Psychogeriatric Outreach Teams, Toronto Distress Centres and the Community Navigation and Access Program (CNAP) network of over thirty agencies. In 2016/17, 9% of SCSI's total referrals (157) were received from 15 Toronto-area hospitals and rehab centres and 4% of total referrals were received from eight Toronto Police Service divisions. In 2017/18, the SCSI responded to 5,187 crisis calls, representing an annual increase of over 300%.

• Expanded Access to Inter-Professional Care in City of Toronto Priority Neighbourhoods: The ETHP will expand models of Inter-professional Primary Care Teams and Neighbourhood Care Teams across our priority neighbourhoods in Year 1, including.
o A new Multi-Service Hub in Thorncliffe Park: Health Access Thorncliffe Park, a formal collaboration between Flemingdon Health Centre and The Neighbourhood Organization, provides primary care and wraparound health and social services to the Thorncliffe Park community, and is leading the development of a new multi-service neighbourhood centre scheduled to open in 2021.
o Expanding access to Inter-Professional Care Teams in Neighbourhoods: To address high usage of the hospital emergency department, and to better link community-based inter-professional teams to local family physicians, we established Interprofessional Care Teams (ICTs) in Thorncliffe Park, Oakridge and Taylor-Massey. Our ICTs link a range of front-line care staff (nurses, social workers, care coordinators, counsellors) from different community agencies with primary care and staff from other local services, including Toronto Community Housing and newcomer organizations. These integrated teams provide support and services for residents ranging from mental health, transitional housing, social isolation, settlement, food security, social care, and family supports. In Year 1, we will complete the integration of care for our two Interprofessional Care Teams (ICTs), and at maturity, we will expand access to neighbourhood-based inter-professional teams through our EasT-FPN and community service partners. These models have led to an improved overall wellbeing of clients/patients, reduced hospitalizations and improved planned care for individuals with complex care needs. In 2017/18, 304 individuals were served, involving 4,071 service provider interactions, with 174 coordinated care plans

completed.

3.3. How do you propose to provide care coordination and system navigation services?

Seamless and effective transitions, 24/7 access to coordination of care, and system navigation services are key components of the Ontario Health Team model. Care coordination and system navigation are related concepts. Generally, care coordination refers to "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient" (Care Coordination. Agency for Health care Research and Quality (2018). System navigation activities can include helping people understand where to go for certain types of care and facilitating access to health and social services. Teams are expected to determine how best to implement 24/7 access to coordination of care and system navigation services based on the needs of their patients and which members of the team are best suited to play this role.

3.3.1. How do you propose to coordinate care?

Care coordination is a critical element of high-performing integrated care, particularly for patients who require higher-intensity care. Considering the needs of your Year 1 population, please propose how your team will coordinate care for these patients. In your proposal, describe whether any of the members of your team have experience coordinating care across multiple providers and care settings.

Describe what activities would be in and out of scope for your care coordination service in Year 1. Describe which patients will have access to care coordination services, how they will access the service, and whether care coordination resources will be organized differently from how they are currently deployed in order to better serve your population. Indicate whether your team will coordinate any care beyond the in-scope services provided by your immediate team.

Describe who (i.e., what type of staff, which organization) would provide care coordination, how many existing FTEs would be assigned to this service, and whether your team has sufficient existing capacity to meet the anticipated care coordination needs of your Year 1 population. Please specify if your plan involves the use of LHIN care coordination resources.

Describe how you will determine whether your care coordination is successful.

Max word count: 1000

The ETHP have a strong foundation of coordinating care, particularly for high intensity/high need populations, building on our experience with Health Links, Neighbourhood Care, and Interprofessional Care Teams.

Our combined care coordination resources will be a key component of our model for integrated service delivery. As outlined in Appendix A, we understand that the redesign of home and community-based care must leverage the knowledge and skills of our patients, caregivers, community and partners to inform the future. We have outlined the following key principles as we set out on our path:

1. We will co-design and build interconnected systems of care in local neighbourhoods with patients, caregivers, home and community care providers, primary care, acute care, community support services, long-term care, and other partners
2. We will ensure that care coordination and system navigation will be key functions in the future health system to support easier access for patients, caregivers and providers to the services they need
3. We will innovate and implement tests of change to help people (patients, caregivers, physicians, and staff from our organizations) understand how we will transition to new ways of working together that will define our future system

All patients within the Year 1 population who require care coordination services will have this access.

Access from Hospital: currently, LHIN care coordinators who are embedded in Michael Garron Hospital and Providence Healthcare (Unity Health Toronto) support patients to transition into the community to ensure that they have the required supports and services. They are responsible for ensuring a warm hand-off to the geographically-based care coordinators who provide ongoing support in the patient's home if required.

In November 2019, the LHIN Hospital Care Coordinators and MGH Transition Team will be co-located to a shared space to enable more seamless coordination across these functions and improve communication and integration of transitions from hospital to community, including better support for patients and families. In Year 1, we will implement tests of change at both Michael Garron Hospital and Providence Healthcare (Unity Health Toronto) to create one team with staff responsible for navigation across the in-hospital continuum for patients with complex care needs that includes:

1) Integrated access to home and community care services and primary care supported by specialty care
2) A standard identification tool for complex patients
3) One point of contact (patient navigator) across the hospital for complex patients
4) One common and accessible assessment

5) One collaborative care plan accessible by full circle of care
6) Accessible and shared electronic record

We will also embed staff from community support and home care service providers as part of this team to support a full range of patients who need home and community care services when they leave the hospital, in support of our vision for 'a system without discharges'.

Access from Community and Primary Care: In our current state, there are LHIN care coordinators embedded in the 21 East Toronto neighbourhoods; with solid integration into the South East FHT and ongoing collaboration with other members of the EasT-FPN and Interprofessional Care Teams. In addition, Care Coordination functions exist in community support services, home care service providers, primary care models and other organizations across East Toronto.

In Year 1, we will:
o assess the capacity we need for coordination and navigation support and determine how to best use our combined staffing resources to care differently for our populations. In time, as we move closer to our vision for 'a system without discharges', patients and caregivers will need less support for care coordination and we can begin to utilize our staffing resources to their full scope of practice to address other gaps in care, including but not limited to expanding support for caregivers, supporting patient self-management and caregiver education, improving health literacy, and expanding care to support the full social determinants of health in our communities.
o establish a more integrated team (with staffing from hospitals, home care, service providers, and community support services) in our two hospitals that combines functions for intake, system navigation, assessment, service ordering, care planning and transition from hospital with continued support into the community
o implement a community-based test of change in our neighbourhood care team model that enables us to expand direct referrals to home care service providers and improve communication with primary care and other community-based services.

Our goal is to make a positive impact on communities in East Toronto by
o Reducing inappropriate / avoidable ED and hospital use
o Eliminating duplication (roles, assessments, communication)
o Simplifying navigation
o Improving efficiency in service delivery and,
o Better utilizing our existing staffing resources to deliver greater value to patients and the system

How will we determine if care coordination is successful?
Health Quality Ontario has recently published guidelines on Transitions from Hospital to Community (https://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Transitions-from-Hospital-to-Home) and we will

engage with partners across the various sectors and patients and families to establish the most meaningful quality measures using the guidelines.

For our Substance Use and Health Populations
In Year 1, to improve coordination of care we will focus on understanding what services and programs are available, their capacity, and barriers to entry through asset mapping exercises and situational analyses. This work has already begun with the Youth Mental Health population, and in Year 1, we will partner spread and scale its use and to provide a single point of access and intake for care coordination / service navigation for ETHP.

In addition, we will improve coordination of care through specific, targeted initiatives including:
o Co-locating multiple services in a Substance Use hub in the Oakridge neighbourhood to improve coordination and access to a range of services such as counselling, system navigation, harm reduction, and housing.
o Establishing 8 women's withdrawal management beds in East Toronto (where none currently exist) that include care pathways across partners that can support this population
o Exploring a partnership to embed community mental health staff in the MGH emergency department to facilitate a warm transition and coordination with community services.

3.3.2. How will you help patients navigate the health care system?

Patients should never feel lost in the health care system. They should be able to easily understand their options for accessing care and know where to go for the services the need. Considering the needs of your Year 1 population, please propose how your team will provide system navigation services for your Year 1 population. Describe what activities are in and out of scope for your system navigation service in Year 1. Describe which patients will have access to system navigation and how they will access the service. Indicate whether system navigation will be personalized (e.g., will the system navigator have access to a patient's health information).

Describe how the system navigation service will be deployed and resourced, and whether your team has sufficient existing capacity to meet the anticipated navigation needs of you Year 1 population.

Describe how you will determine whether your system navigation service is successful.

Max word count: 1000

This section builds on our response to section 3.3.1. Our future state for system navigation mirrors that of care coordination in that our intent is to build interconnected systems of care in our hospitals as well as in local neighbourhoods with care coordination and system navigation as key functions. All patients will continue to have

access to the system navigation supports they have now through our existing supports in hospitals, home and community care, service providers, and primary care. At the same time, we will test new approaches to system navigation, particularly for higher risk/higher needs patients in our two hospitals, our interprofessional, neighbourhood care models and patients supported by home care service providers.

In addition, we will be building on existing system navigation assets and approaches we have in East Toronto, including:

Telephone-Based Navigation and Referral Support:
The Toronto Senior's Helpline, which began as a joint venture between the Toronto Central LHIN and WoodGreen is available for seniors and their caregivers to receive community, home and crisis support. This service coordinates access to community support services in the TCLHIN via warm telephone transfers and Resource Matching & Referral. Toronto Seniors Helpline is also the assessment and entry point for the Crisis Outreach Service for Seniors, which offers interdisciplinary in-person crisis support and short-term case management support every day of the year through WoodGreen Community Services, Reconnect Community Health Services, LOFT, South Riverdale Community Health Centre and Haven Toronto.

Youth with Mental Health Needs:
Our aim is to work towards creating a system with "no wrong" door, enabled by improved lines of communication between organizations so that clients are able to be directed to the right resources and their information is passed to those resources seamlessly. For Year 1, the youth we have engaged across our community have requested easier, on-line access to local support services. We will be working with them to assess the current digital resources are available, including, but not limited to Kids Help Phone, OTN's Big White Wall, and other apps to determine gaps in information and accessibility.

SCOPE – Seamless Care Optimizing the Patient Experience:
SCOPE is a service platform with the goal of building a partnership between family physicians and hospital-based and community-based resources, by providing a virtual interdisciplinary team for family practice. SCOPE offers simplified access through a single point of contact; physicians call one phone number to reach a General Internist, a Home and Community Care Coordinator, a Nurse Navigator, and Diagnostic Imaging at Michael Garron Hospital. The SCOPE phone line enables physicians to have improved access to care for their complex chronic disease patients in the community through telephone advice, expedited appointments, coordinated care and follow-up, and potential reduction of Emergency Department visits.

Since the launch at the end of February/2019, 70 primary care physicians have registered with SCOPE, and there have been over 200 calls, with a majority of calls to the Nurse Navigator.

The SCOPE program at Michael Garron Hospital is being further expanded to include

a Mental Health pathway for Youth and Adult Mental health, and for patients with Substance Use concerns.

The SCOPE program is fully aligned with the goals of the OHT in improving care for patients in the community, with SCOPE being able to facilitate change driven by family practice needs.

Providence's Community Health Navigators:
Providence's Community Health Navigators role is to help patients transition home safely, reintegrate into the community, improve quality of life, and decrease the risk of subsequent hospital readmissions. Our Community Health Navigators follow up with our patients post discharge at 48 hours, 30 days, and 4 months to evaluate progress, reintegration into the community with the Reintegration to Normal Living Index tool, and to see how well their caregivers are faring, through the Caregiver Strain Index. In 2018/19, this included almost 6500 calls to patients. We are able to make these follow up calls in multiple languages to serve our culturally diverse population.

Assessing other Navigation Tools:
Through our Digital Health Strategy, we recognize there are many navigation tools that can help patients and providers navigate the health care system. The Health Services Directory, hosted by OTN, has a comprehensive web-based repository of specialists and community providers within the Toronto Central LHIN. While a log-in credential is required for full access, a limited set of information is still publicly available without a log-in. Lumino Health, created by Sun Life, is another online directory that provides information on over 150k health providers, such as dentists, chiropractors, etc, listed across Canada. IamSick and 211 Ontario are other examples of directories that can help a patient navigate the health care system. SCOPE, an initiative started out of Women's College Hospital, has been successfully rolled out in east Toronto this spring and is now being aligned as a tool to engage and register more family physicians in joining the EasT-FPN.

In Year 1, we will be doing an assessment of existing navigation and support tools to understand the current landscape of assets as well as identify gaps for our East Toronto populations. We will also actively use these tools to broadcast to patients and caregivers information about our enhanced services and hours during the fall/winter surge. Our intent is not to duplicate existing services, but to assess how we can better utilize existing resources and services that are regional or province-wide to better serve our local populations.

3.3.3. How will you improve care transitions?

Patients should experience seamless transitions as they move from one care setting or provider to another. Beyond care coordination and system navigation, please identify any specific actions your team plans to take to improve care transitions and continuity of care for your Year 1 population. Describe what initiatives or activities the members of

your team currently have in place to improve transitions and explain whether and how you will build off this work in your first year of implementation.

Describe how you will determine whether you have improved transitions of care.

Max word count: 1000

Our plan to improve transitions builds on our response to section 3.3.1. Transitions are critical and vulnerable points in the provision of healthcare. We have heard from patients, caregivers and families, examples of challenges they face with consistency, reliability and timeliness of services. Patients and caregivers also cite challenges with hospital discharge processes such as insufficient communication, and a lack of patient and caregiver involvement in the process.

We have identified two initial areas of focus in which patients would benefit from improved transitions:
1) Transition of care as patient's complexity changes and patients move between providers, and
2) Transitions between hospital, community and primary care

The work to connect care coordinators to primary care, community support services, home care providers, and hospitals ensures that each patient has a single point of contact that is responsible for supporting that patient as needs and/or intensity of care change and ensuring that a seamless transition occurs as required to meet care needs.

In addition to the changes described in 3.3.1 that will address the need for improvement in care transitions, we have work already underway in East Toronto through the MGH Virtual Ward, the SETFHT TC-LHIN homevisit program, the neighbourhood care initiative, via weekly virtual and in person team huddles. The objective of the huddles is for geographically based teams to discuss significant clinical or support concerns raised by clients/patients/caregivers or any team provider. It also provides the opportunity to identify increased needs or high-risk patients and streamlines communication between providers. High risk patients leaving hospital are linked to a family physician and primary care team, to the homevisit program if homebound, or the Telemedicine Impact Plus (TIP) program if the complexity also involves psycho-social components; all these programs were created in our community and started a decade ago to improve transitions in care. Patients discussed in the huddle have an identified "most responsible provider" who acts as the main point of contact for the patient/caregiver and the care team. This approach facilitates providers to work together, communicate frequently, share information, and work in partnership with clients and family caregivers. We will continue to build off the work that has been initiated in seniors' buildings in East Toronto with a goal of expanding to all East Toronto neighbourhoods at maturity.

The East Toronto Partners also have initiatives underway to support seamless

transitions from hospital to home. For our "high risk population" who require fully integrated care we will provide:

- Warm handoffs between OHT team members to ensure there are no lapses in care
- Navigators embedded in the Hospital to facilitate navigation and support patients into the Community
- Navigators and coordination staff in our neighbourhood-based models who will support patients' transition into hospital and then work with patients, caregivers and the hospital teams to support the transition back home
- Strong connection to Primary Care
- Digital support that enables data exchange for patient care and facilitates collaboration amongst team members

For our "low risk and rising risk population" who require care coordination support and access to services and supports we will provide:

- Care coordination, which a strong connection to primary care, to support patients into the community, with integrated team-based care for those who require it
- Community navigation and connection to service, including navigators and coordination staff in our neighbourhood-based models who will support patients' transition into hospital and then work with patients, caregivers and the hospital teams to support the transition back home
- Access to preventative health and health literacy support, through patient, family and caregiver education and training to empower self-navigation when possible
- Access to their health information digitally and on-line self-management tools that will help enable them to participate actively in their care

To measure progress on transitions, we will measure:
High risk

- Increased # patient satisfaction/ reported outcomes (PROMs)
- Increased # patients connected to a Health Navigator
- Reduced # of hospital readmissions

Risking-Risk

- Increased # patient satisfaction/ reported outcomes (PROMs)
- % of seniors that have access to interprofessional primary care team (NCTs, ICCT, EPIC, House Calls, CHCs)
- Reduced ED visits and admission

Low risk

- % of patients with access to digital health record

Mental Health and Addictions

- Increase capacity to facilitate warm hand offs where appropriate. We are examining the feasibility of implementing different transition models where community care workers help facilitate the transition to community services for those experiencing mental health and substance use issues presenting in the Emergency

Department.
- Increase relationships and trust between referring and receiving providers through team building, joint training, and co-design sessions that include multiple partner organizations.

Digital Enablers
- MGH is HRM and eNotification enabled – supports notifying primary care of hospital activity including discharge summaries
- Most anchor partners have electronic coordinated care plans – to support care planning and transitions in the community
- 11% of Primary Care Physician's in East Toronto are active eConsult users – avoid unnecessary referrals by connecting primary care to specialists

3.4. How will your team provide virtual care?

The provision of one or more virtual care services to patients is a key Year 1 service deliverable for Ontario Health Teams. Virtual care enables patients to have more choice in how they interact with the health care system, providing alternatives to face to face interactions. This includes virtual visits that allow patients to interact with their healthcare providers using telephone, video or electronic messaging; websites and apps that provide patients with easy access to their health records; innovative programs and apps that help patients manage their condition from their homes; and tools that allow patients to book appointments online and connect with the care they need. Ontario's approach to virtual care makes care more convenient for patients, provides patients with choices about how they receive and manage care, and ensures that virtual care is only used when clinically appropriate and preferred by the patient. At maturity, teams are expected to provide patients with a range of digital choices.

Please refer to *Appendix B – Digital Health* to provide your proposed plan for offering virtual care options to your patients.

3.5. How will you support patients (and caregivers) to be active participants in managing their own health and health care?

3.5.1. How will you improve patient self-management and health literacy?

Evidence from high-performing integrated systems shows that new approaches to care need to be flexible and adaptive to individual patient goals. Describe your proposed plan for helping patients manage their own health. Describe which of your Year 1 patients (e.g., which health conditions) will receive self-management and/or health literacy supports, and the nature of those supports. Include a description of your team's existing self-management and health literacy tools, processes and programs, and describe how you will build off this existing infrastructure to enhance these functions for your Year 1 population.

Max word count: 500

Supporting our Year 1 Populations:
The ETHP recognizes that helping patients manage their own health is an important means to achieve the Quadruple Aim by improving patient experience, improving health outcomes, reducing caregiver burnout, and reducing health care costs. For each of our Year 1 populations, improving self-management and health literacy are essential components of our strategy.

o For seniors with chronic disease and their caregivers we will use technology to address three objectives: support patients' access to their health information/electronic health record (EHR); self -monitoring tools to help them manage their conditions and address changing indicators such as blood pressure, blood sugar etc.; and, self-management tools to maintain health and provide education and training to clients and caregivers related to their health conditions and reduce caregiver burnout.

o For youth with mental health needs, we will implement digital navigation tools for local assets and programs for youth mental health and wellness services. The digital navigation tool design will be selected with youth who are currently engaged with this work stream.

o For adults with substance use needs, we will develop an education strategy that will deliver information through existing channels (e.g. social networks) to reach clients virtually

The Citizen-led Digital Health Working Group from the Toronto Central LHIN region is working on a number of initiatives to help improve patient access to information, connecting providers and services and improving digital health literacy that can be leveraged by OHTs. There are products being developed by this group that can be leveraged by ETHP, including an FAQ document that educates patients about their rights to digital information.

Existing Self-Management and Health Literacy Supports:
Across the ETHP, there are a number of existing self-management and health literacy tools we will leverage to support our Year 1 populations, examples include:

- South Riverdale CHC delivers "Choose Health" – self-management programs for community members living with long term health concerns, their caregivers, as well as their health care providers. These trainings, programs, and services promote skills to help people live well with long term health issues. Programs are provided in partnership with local agencies and community groups and have focused on City of Toronto priority neighbourhoods.
- Several ETHP organizations provide educational materials to clients, and potential clients, through their publicly accessible websites
- The Scotiabank Learning Centre at Providence Healthcare (Unity Health Toronto) is a multi-faceted resource centre for families learning to cope with life-altering illnesses such as diabetes, stroke, heart disease, dementia, arthritis and Parkinson's.
- Michael Garron Hospital has deployed CoHealth, a mobile application that a

patient can use when leaving the hospital's emergency department. It allows the user to load educational documents, as well as future appointment reminders. MGH also deployed SeamlessMD to its Thoracic Surgery patients, enabling patient education, self-care and reporting, and ongoing monitoring by their surgeons to ensure post-operative recovery and support. The hospital will expand this or other technologies to support the Home 2Day program for similar self-care management and remote monitoring'

• VHA Home HealthCare, as a Best Practice Spotlight Organization (BPSO), has adopted the RNAO's Chronic Disease Self-Management Best Practice guideline. Staff and providers attend the Choices and Changes workshops and receive in-house support from chronic disease management Clinical Leads.

3.5.2. How will you support caregivers?

Describe whether your team plans to support caregivers and if so how. In your response, include any known information about caregiver distress within your community or attributed population, and describe how your plan would address this issue.

Max word count: 500

Toronto Central LHIN home and community care data shows high reported caregiver distress; 38.9% of caregivers, with rates as high as 47% in specific East Toronto neighbourhoods. Rates of caregiver distress have increased annually for the last 5 years. These data reflect caregivers for seniors with complex/chronic needs and therefore rates will be even higher when we consider other populations such as parents of children with complex care needs or mental health issues, caregivers of adults with significant disabilities and/or multiple complex/chronic diseases, and caregivers supporting family members with end-of-life care.

Caregivers play a vital role in keeping residents safe and healthy at home and we acknowledge the importance of measuring distress and reducing caregiver burden; we will:

☐ Expand our patient assessments to include caregivers and family members: Assessing caregivers and family members to understand their capacity, ability and willingness to provide care. This includes asking what is most important to them and what kinds of support they need to fulfill their vital role as part of the care team.

☐ Provide caregivers support and respite: Care for caregivers needs to be included as part of the designated patient's care, including providing supports through the integrated team as necessary to support the patient and caregivers in their home and access to respite services in local communities.

☐ Provide resources and tools for Caregivers – Providing better access to peer support groups, self-help resources, and education for caregivers. We will leverage existing services including the Toronto Seniors' Helpline as described in section 3.2 and SE Health's Elizz platform which allows for 24/7 support via a chatbot and access to caregiver coaches for virtual support

Across our Year 1 populations, we will establish improved supports for caregivers by:
- Assessing existing programs and materials that support caregivers across organizations to understand strengths and gaps, looking for opportunities to spread and scale, and refer to these services.
- Harmonizing programs to ensure that best practices are consistent across all programs.
- Establishing a joint Patient and Family/Community Advisory Council for ETHP to provide advice and assistance with identifying and addressing opportunities to engage with caregivers to understand their needs and how they wish to be supported.

3.5.3. How will you provide patients with digital access to their own health information?

Providing and expanding patients' digital access to health information is an important part of the Ontario Health Team model in Year 1 through to maturity.

Please refer to *Appendix B – Digital Health* to provide your proposed plan for providing patients with digital access to their health information.

3.6. How will you identify and follow your patients throughout their care journey?

The ability to identify, track, and develop sustained care relationships with patients is important for strengthening relationships and trust between patients and providers, implementing targeted care interventions, and supporting clinical follow up and patient outcome measurement.

Describe the mechanisms, processes, and/or tools that your team proposes to use to **collectively** identify, track, and follow up with Year 1 patients.

Max word count: 500

A key strategic approach for the ETHP is to enable a digital-first customer service concept that includes facilitating the process of identifying, tracking, and developing relationships with citizens that are served as part of the OHT community. This insight will be used to provide patients with care that considers their life context, provides an equity and population-based lens, and enables targeted interventions to ensure that the right outcomes are met.

From a digital perspective, the ETHP is considering options for implementing a customer relationship management (CRM) tool that would allow all providers to have a single view of the citizen's profile. At minimum, the solution should identify patients, present socio-demographic information relevant to that person's care and experience, and track interactions in a way that demonstrates seamless connection between various care settings. Furthermore, the system will be an integrated part of the digital suite of tools that each provider uses, and data collected must be available for reporting and business intelligence.

Currently, the team is in the process of defining specific requirements and engaging with other OHTs to confirm a collaborative approach on this. In particular, should there be a need to procure a solution, the intent would be to do so as a collective, multi-OHT consortium. An investment will be required to establish and mature a CRM platform, and as part of an embedded population health management solution at ideal state. As an identified need among many OHTs, the ETHP considers this a priority for the Ministry to consider supporting from a provincial perspective. Section 4.3.1 highlights the recommended integration within the local OHT ecosystem as well as with provincial assets.

In parallel, the team is exploring immediate options as an interim means to identify and track patients on defined pathways, leveraging existing systems such as CoHealth and SeamlessMD. More broadly, the ETHP will leverage care coordinators within the OHT to help maintain an interim record using existing systems.

The ETHP will assign care coordinators to Year 1 patients. The care coordinators will be responsible for enrolling patients into the ETHP OHT and for maintaining a master patient list in a non-distributed CRM platform that will serve as the baseline data for the longer-term CRM solution when available for implementation. The care coordinator will be responsible for notifying the care team that a patient has been enrolled in the ETHP OHT. Notifications will be facilitated through secure email, HRM, and CHRIS.

Year 1 patients will be tracked within both the master list and the respective information systems of the ETHP members. Upon implementation of the CRM solution, all anchor partners will have universal access to a single, comprehensive view of the enrolled patients. At maturity, ETHP aims to exchange health data with the CRM and population health management solution to enable proactive interventions more seamlessly across the continuum of care.

3.7. How will you address diverse population health needs?

Ontario Health Teams are intended to redesign care in ways that best meet the needs of the diverse populations they serve, which includes creating opportunities to improve care for Indigenous populations, Francophones, and other population groups in Ontario which may have distinct health service needs. In particular, Ontario Health Teams must demonstrate that they respect the role of Indigenous peoples and Francophones in the planning, design, delivery and evaluation of services for these communities.

Considering your response to question 1.3 and according to the health and health care needs of your attributed population, please describe below how you will equitably address and improve population health for Indigenous populations, Francophones, and other population groups who may experience differential health outcomes due to socio-demographic factors.

3.7.1. How will you work with Indigenous populations?

Describe whether the members of your team **currently** engage Indigenous peoples or address issues specific to Indigenous patients in service planning, design, delivery or evaluation. Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Indigenous health or health care needs in Year 1 or longer-term.

How will members of your team provide culturally safe care? Does your team include Indigenous-led organizations as members or collaborators? Why or why not?

Max word count: 500

Although East Toronto does not have any land set aside for First Nations, it does have a large Indigenous population of 13,778 people; however, we recognize the valuable work of 'Our Health Counts Toronto' in demonstrating that the most recent Canadian census underestimated the size of the indigenous population in Toronto by a factor of 2 to 4. This population generally has higher rates of low income, high rates of health conditions and mental health conditions. Many of the ETHP have Aboriginal programs delivered in partnership with Aboriginal leaders and Elders. Moving forward, we will continue to engage with Aboriginal leaders and Elders, building on the principles of engagement of the Toronto Indigenous Health Strategy, to provide culturally appropriate and sensitive services to shape how we can better support and serve our Aboriginal community members, and families in East Toronto. The ETHP is committed to supporting the rights of our indigenous communities to self-determine how they will engage with the OHT work.

On August 13, 2019, Michael Garron Hospital, Toronto East Health Network and members of The Aboriginal Healing Program hosted the opening of the “Bear’s Den Traditional Medicine Sweat Lodge” located on the hospital’s property. The Ceremony was led by Elder Little Brown Bear, Manager of Aboriginal Culture at MGH.

The First Nations, Metis, Inuit and Indigenous Health Community Advisory Panel at Unity Health has been established to advise on issues related to the provision of culturally aware, sensitive, competent, safe and holistic services

Our members have been active supporters of Indigenous Cultural Safety, demonstrated by our commitment for staff to complete the Indigenous Cultural Safety training. Indigenous Cultural Safety (ICS) training is an online program. The overarching goal of the online ICS training course is to begin an important educational journey that will contribute to improved patient experiences; access to health services and improved health outcomes for Indigenous people. Over 90 representatives of our anchor partner organizations have taken the training since 2018, and we are planning for additional participation in the year ahead.

3.7.2. How will you work with Francophone populations?

Does your team service a designated area or are any of your team members designated or identified under the French Language Services Act?

Describe whether the members of your team **currently** engage Francophone populations or address issues specific to your Francophone patients in service planning, design, delivery or evaluation. (This includes working towards implementing the principle of Active Offer). Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Francophone health or health care needs in Year 1 or longer-term.

Max word count: 500

The City of Toronto is one of the 26 French Language Services (FLS) designated areas in Ontario (Ministry of Francophone Affairs). Only the Toronto Central LHIN Home and Community Care is an identified health service provider under the French Language Services Act (FLSA) among the East Toronto Health Partners. However, there are two designated health service providers in Toronto, namely Les Centres d'Accueil Heritage (CAH) and the Centre Francophone de Toronto (CFT) providing services in French across the Greater Toronto Area.

The CAH is one of the partners of the Toronto Seniors Helpline and provides both crisis and supportive counselling in French and triages crisis calls to the Crisis Outreach Service for Seniors team for in-person visits. The CFT is a community health centre and provides primary care services in French in Toronto.

The East Toronto Health Partners ensures alignment with the Guide to Requirements and Obligations Relating to French Language Health Services to develop mechanisms to address the needs of its local Francophone community, including the provision of information on local health services that are available in French and in general, better serve Francophones and improve access to linguistically and culturally appropriate services. Our team promotes the principles of Active Offer, as confirmed in our Self-Assessment submitted to the ministry earlier this year and endorses obligations and responsibilities to French Language Services by applying a Francophone lens when planning and delivering health services in order to improve Francophone's access to appropriate care. In 2018-19, 100% of our partners in East Toronto had completed the Human Resource Capacity Plan section of their required FLS report and a total of 40 Francophones was identified as 'French-speaking' and received services across the health service providers (HSPs) in East Toronto. 62% of HSPs in East Toronto have a process in place to 'identify' language of preference for service delivery (OZi Report, 2019).

The East Toronto Health Partners have undergone the Leadership Training on Active Offer, organized by Les Centres d'Accueil Héritage to ensure that all of our partners are made aware of the principles of Active Offer to support the needs and

demographics of the Francophone population in Year 1 and at maturity.

The East Toronto Health Partners, in collaboration with Reflet Salvéo, has leveraged the needs assessment conducted on seniors and caregivers as well as people living with mental health conditions and addictions across the Francophone community. A number of recommendations was made and are being considered by the East Toronto Health Partners in service planning, design, delivery or evaluation as part of Year 1 and at maturity.

The East Toronto Health Partners will continue to leverage collaborative approaches with Reflet Salvéo and other partners, such as the Fondation Hélène Tremblay Lavoie Foundation, to develop specific care pathways aligned with leading practices to plan and deliver care for Francophones.

3.7.3. Are there any other population groups you intend to work with or support?

Describe whether the members of your team currently engage in any activities that seek to include or address health or health care issues specific to any other specific population sub-groups (e.g., marginalized or vulnerable populations) who may have unique health status/needs due to socio-demographic factors. Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities in Year 1 or longer-term.

Max word count: 500

For the last several years, CHCs, MGH and Unity Health have participated in collection of the TC LHIN Health Equity data through voluntary anonymous patient questionnaires that ask patients to respond to a series of questions related to cultural identity, ethnicity, religion, sexual orientation, and other personal information that enables the TC LHIN to identify service patterns and equity gaps for specific populations. The ETHP partners have used this information in different ways, for example MGH has used the data to improve maternal and newborn care for indigenous families. We believe ongoing and increased collection of this information across more of our ETHP partners will expand our knowledge of health inequities in our community and provide us with essential information to help address gaps. At this point in time we are uncertain of how TC LHIN's work in health equity will continue in the restructured LHIN context, but we strongly advocate for this to continue and have included this as a recommendation in section 6.5. The Dalla Lana School of Public Health has indicated they would be interested in supporting our health equity data collection through a collaborative partnership; we will be exploring this opportunity further.

The East Toronto Health Partners serve a significant number of uninsured individuals, with 714 accessing Community Health Centres (CHCs) in East Toronto in 2016/17. This service will continue in Year 1 and longer-term.

Priority Neighbourhoods: Victoria Village, Oakridge, and Taylor-Massey had notably high levels of marginalization. These neighbourhoods are receiving specific focus in Year 1 implementation strategies:

☐ There are 18 Toronto Community Housing (TCH) Seniors' Buildings in East Toronto. The East Toronto Health Partners have committed to partnering with TCH and the City of Toronto in an Integrated Service Model in these buildings in 2020. Part of this model is to establish service hubs for seniors' services available to residents.

☐ Specific mental health and substance use initiatives aimed towards connecting with immigrant, refugee, ethno-cultural and racialized populations are being explored, and engagement sessions with these populations are being planned. The needs of these populations are being considered within existing initiatives.

☐ We will continue to foster an LGBTQIA2 inclusive environment building on the partnership with The 519 organization and expanding training to front-line staff in East Toronto - to enable a welcoming, appropriate care environment across all sectors.

3.8. How will you partner, engage, consult or otherwise involve patients, families, and caregivers in care redesign?

Describe the approaches and activities that your team plans to undertake to involve patients, families, and caregivers in your Year 1 care redesign efforts. Describe how you will determine whether these activities have been successful.

Max word count: 1000

A number of sessions have already been hosted by the East Toronto Health Partners, working together and involving patients, families and caregivers in care redesign.

Several examples are listed below:

- Client and Caregiver Advisory Engagement Sessions (Aug and Sept 2019)
- Community Surge Planning Workshops (Aug and Sept 2019)
- Community Planning Workshops for Substance Use and Health (Aug and Sept 2019)
- ETHP Community Webinar (Sept 2019)
- Home Care Planning Session (Sept 2019)
- South East FHT Patient Advisory Council update on OHTs (Sept 2019)
- Hospital to Home Transitions, Value Stream Mapping (Sept 2019)
- Seniors with Chronic Disease and Caregivers Design Workshop (Sept 2019)
- Youth Mental Health and Wellness Asset Mapping (July 2019)
- Two full day co-design sessions (March/April 2019)
- Youth Mental Health and Wellness workshop (March 2019)

From the above list, specific examples of how we have engaged patients and caregivers in co-designing the work of the ETHP include:
o Our Youth Mental Health and Wellness Asset Mapping Workshop held in July involved more than 30 youth from across East Toronto helping us identify and prioritize improvements to services for youth mental health and wellness. Their recommendations from this session are included in this application.
o Our Home Care Planning Session held in September involved four patient and caregiver advisors (who had received home care services) in the design and running of the session including: creating the agenda; identifying and presenting on the most important elements of home and community care redesign for patients, families and caregivers; participating in the discussion with the home care providers and primary care representatives who attended the session; and, presenting their reflections on the session at the end. Their contributions are reflected in the home care model design as outlined in Appendix A.
o We have citizen representatives at both our digital committee and at the regional digital planning table to advise us on digitally-enabled health care that will work better for patients and caregivers.

As described in sections 2.10 and 4.2, the ETHP established a Patient and Caregiver Engagement Planning Team consisting of advisors from existing Patient and Family Advisory Committees from the different Anchor Partners and the Toronto Central LHIN to advise on different approaches to patient, family, caregiver and community engagement. Based on their recommendations, moving forward the East Toronto Health Partners will:
- Establish a joint Patient and Family/Caregiver Advisory Council to support the work of the ETHP and advise us on our approaches to patient, family, caregiver and community engagement
- Work with the Joint Patient and Family/Caregiver Advisory Council to identify representation at the Governance Level for ETHP
- Work with the Joint Patient and Family/Caregiver Advisory to identify how best to continue our engagement with patients, caregivers and our community in our work, including co-designing new approaches to care for our priority populations.

Through our ongoing engagements, we will track the improvements/service redesign changes that are identified, and we will report back to participants and our community about the change activity that is taking place based on inputs from our different sessions.

Success of our engagement of patients, families and caregivers will be measured based on their satisfaction with our efforts and the number of change ideas implemented.

Ontario Health Teams
Full Application Form

4. How will your team work together?

4.1. Does your team share common goals, values, and practices?

The development of a strategic plan or strategic direction that is consistent with the vision and goals of the Ontario Health Team model (including the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management) is a Year 1 expectation for Ontario Health Team Candidates. Describe the degree to which the members of your team already share common organizational goals, values, or operating practices and how these align with the Ontario Health Team model. Where there are differences, please describe whether they would need to be addressed as part of your partnership going forward.

Max word count: 500

The ETHP has established a shared vision and guiding principles that form the foundation of our Joint Venture agreement and align with the vision and goals of the Ontario Health Team Model. Our shared vision is centred on creating 'a system without discharges'; one connected system of health care and support for all residents in East Toronto. Our shared principles describe how we will work together to achieve our vision.

A specific example of how we use our shared vision and guiding principles is our winter surge planning. Annually we experience an increase in demand for patient care due to flu, chronic disease and respiratory illness as well as increasing mental health challenges due to the pressures of the holiday and winter season.

In response to winter surge last year, the ETHP invested $1.5M into a range of hospital and community-based services to better meet the needs of our local community. This year, the ETHP will invest $1.8M into community surge efforts. The ETHP hosted two collaborative workshops with partners this summer to focus on key principles, evaluation criteria and identify specific 2019/2020 community surge priority activities.

During the past two years, the ETHP's commitment to shared values, accountability and collaborative action has helped strengthen trust across the partnership, enabling us to focus on tangible efforts to improve care in our community. Most importantly, the ETHP anchor partners commit to sharing organizational resources to create an East Toronto health and community care system that places the needs of our community above the interests of our individual organizations. We are motivated to act with a deep level of integrity and acknowledge that the ETHP vision includes shared accountability across providers receiving funding from Ontario Health. The ETHP anchor partners have strong existing digital infrastructures, many common systems across East Toronto primary care partners, and an interest in better integrating digital approaches to improve care delivery.

Our goal is that every person wishing to receive care in East Toronto has easy access

to primary and inter-professional care when they need it in their local community. Together with a growing network of engaged and supporting partners, we designed principles to help achieve our shared goals:
• we are community centered and committed to continuous improvement
• engagement and consultation with service providers, physicians, health professionals, clients, patients and families inform the design of care delivery models and all aspects of our OHT
• health and wellness services across East Toronto are fully integrated
• our processes are inclusive and transparent across the partnership, and within our communities
• we have strong and engaged OHT leadership, driven by our unified vision and aligned values

4.2. What are the proposed governance and leadership structures for your team?

Ontario Health Teams are free to determine the governance structure(s) that work best for them, their patients, and their communities. Regardless of governance design, at maturity, each Ontario Health Team will operate under a single accountability framework.

Please describe below the governance and operational leadership structures for your team in Year 1 and, if known, longer-term. In your response, please consider the following:

- ***How will your team be governed or make shared decisions?*** Please describe the planned Year 1 governance structure(s) for your proposed Ontario Health Team and whether these structure(s) are transitional. If your team hasn't decided on a governance structure(s) yet, please describe the how you plan to formalize the working relationships among members of the team, including but not limited to shared decision making, conflict resolution, performance management, information sharing, and resource allocation. To what extent will your governance arrangements or working relationships accommodate new team members?
- ***How will your team be managed?*** Please describe the planned operational leadership and management structure for your proposed Ontario Health Team. Include a description of roles and responsibilities, reporting relationships, and FTEs where applicable. If your team hasn't decided on an operational leadership and management structure, please describe your plan for putting structures in place, including timelines.
- ***What is your plan for incorporating patients, families and caregivers in the proposed leadership and/or governance structure(s)?***
- ***What is your plan for engaging physicians and clinicians/ clinical leads across your team's membership and for ensuring physician/provider leadership as part of the proposed leadership and/or governance***

structure(s)? For non-salaried physicians and clinicians, how do you plan to facilitate their meaningful participation? What approaches will your team use to engage community-based physicians and hospital-based physicians?

Max word count: 1500

As demonstrated, ETHP has a long history of collaboration, shared service delivery and care integration. There is a strong foundation of trust across the Partners and a momentum to continue this work. ETHP has built on this momentum of trust and collaboration to establish a "Network of Networks" that delivers the Quadruple Aim through our vision of a 'System without Discharges': A seamless continuum of care that is population health focused, with programs tailored to local communities. In October 2019, we welcomed our newest Anchor Partner, the East Toronto Family Practice Network (EasT-FPN) as described in section 2.9

The Leadership model for ETHP is based on a "Network of Networks" model. The Network of Networks model has allowed for broad input from each anchor partner's peer organizations. The small number of Anchor Partners was an intentional starting point, building on 20+ years of relationships among trusted partners across different sectors. The small size of the Anchor Partner table has enabled nimble processes and decision-making; however, the Anchor Partner table was not intended to be static or exclusive and we have started developing processes to evolve our governance model, with clear identification of the expectations and requirements for becoming an Anchor Partner, Engaged Partner or Supporting Partner.

Although the description below describes the current state of our partnership model, in Year 1 we will establish a Governance Committee to identify the strategy for and next steps in the evolution of our governance model. This work will align with the development of our first Strategic Planning process, which will engage our whole community in designing the future state as outline in section 6.1. In the meantime, the ETHP is taking all possible steps to coordinate seamless care across our different partner organizations with the intent that patients and caregivers see and experience us a single team that works with them.

Anchor Partners:
• Formal signatories of the OHT Application and ETHP - includes EasT-FPN, Michael Garron Hospital, Providence Healthcare (Unity Health Toronto), South Riverdale CHC, VHA Home HealthCare, and WoodGreen Community Services
• Responsibility to work with and keep "engaged partners" included in co-design of ETHP work
• Define the ETHP clinical and financial accountability, and integrated leadership and governance. Determine how to share and mitigate risk
• Work to create an East Toronto health system, leveraging our resources, and advocating for our communities over and above our individual organizations
• Make time to engage in ETHP meetings and support subsequent work

• Commit to transparency and communication across the system – engaging partners and others

Engaged Partners:
• Connect to the ETHP through one or more anchor partners
• Kept informed and have input into decisions of the ETHP
• Co-design care pathways
• Commit resources as applicable to the planning and implementation of care pathways focused on improving population health
• Invited to sign-off on and deliver services within specific care pathways (e.g., Youth Mental Health and Wellness)

Supporting Partners:
• Local providers, individuals, faith groups and others who care about the health of the community and critical to local planning; informed and involved periodically, but not formally committed to joining a planning table
• Includes agencies engaged in the wellbeing of the communities they serve; these partners may already be engaged through neighbourhood care teams
• Commitment to keeping people as healthy as possible, supporting social determinants of health, and fostering a sense of belonging across strong communities

Patients, Caregivers and Families:
• Since our inception, the ETHP leaders have engaged patients and community in the co-design of our joint governance, care pathways and digital tools. The inaugural leadership table included two community members to inform our vision, guiding principles, and goals.
• Over the last 6 months, each of our priority population workstreams has included multiple patients, caregivers and family members as contributors to the design of the future state.
• After completing our OHT self-assessment, the ETHP made a decision to pause our existing approach to 'inviting' patients and caregivers to different planning tables, and instead decided that we needed to ask patients and caregivers how they would like us to engage them in our work. To help guide us through the next phase of our OHT work, we asked members of Patient and Family Advisory Committees from different East Toronto provider organizations to participate in an 'Engagement Planning' discussion. In August and September, we hosted two meetings of this group and asked for their advice on different approaches to patient, family, caregiver and community engagement going forward. Our Patient and Caregiver Engagement Planning Team provided specific recommendations for ETHP as next steps (target completion November 30, 2019) including:
  o Identifying a process for us to establish patient/caregiver membership at the Governance level to ensure their voices are part of our strategy, priority setting and decision making
  o Creating a joint ETHP Patient and Family Advisory Council (PFAC); one that addresses gaps in representation to ensure a health equity approach, includes with people with lived experience, and builds relationships and trust with our local

communities
o Engaging the new ETHP PFAC and individual patient advisors in experience-based design, establishing feedback loops where input is continuously provided, to inform ongoing quality improvement efforts
o Determining a fair and consistent approach to compensation and reimbursement of expenses for patients and caregivers who participate in the work of the ETHP.

As outlined in the Joint Venture agreement to be signed by the six Anchor Partner organizations in October 2019, the Anchor Partners will have a contractual agreement that outlines governance, decision-making, dispute resolution, performance management, information sharing, and resource allocation. The agreement is designed to anticipate the addition of new Anchor Partners over time. In addition, the four CHCs in East Toronto have signed a Memorandum of Understanding with South Riverdale CHC as the Anchor Partner to strengthen a primary healthcare system that is accessible and integrated across neighbourhoods in East Toronto, particularly for the 22% of socially vulnerable and medically complex residents who require the CHC model of care

An Operations Table has been established to provide operational oversight of the work of the ETHP to advance integrated care, which is supported by a project team that includes in-kind staffing resources contributed by the different partner organizations. The Operations Table is accountable to the CEOs of the Anchor Partners.

As a next phase of our Joint Venture agreement, we will be working with our Engaged Partners and our legal counsel to draft an addendum that will establish the shared accountabilities of Anchor Partners and Engaged Partners. With our “Engaged Partners”, we will co-design integrated programs that build health among our populations. They will be asked to sign agreements around specific projects through which clinical and financial accountability will be determined. As part of our model, the anchor partners have a commitment and accountability to connect with engaged and supporting partners to foster the ETHP ‘Network of Networks’. Through our existing joint work, we demonstrated a shared commitment to increasing clinical and financial accountability across anchor and engaged partners, through our joint initiatives like Integrated Surge Planning and joint Mental Health and Addictions leadership recruitment. Although defined as specific levels of partnership, important to our ‘Network of Networks’ model is the notion of ‘fluidity’, at both the initiative level and highest level of network leadership and governance – where the ETHP is open to movement of partners across the different tiers, as we expand and strengthen the partnership.

4.3. How will you share patient information within your team?

At maturity, Ontario Health Team will have the ability to efficiently and effectively communicate and to digitally and securely share information across the network, including shared patient records among all care providers within the system or network.

4.3.1. What is your plan for sharing information across the members of your team?

Describe how you will share patient information within your team. Identify any known gaps in information flows between member organizations/providers and what actions you plan to take to mitigate those gaps (e.g., are data sharing agreements or a Health Information Network Provider agreement required?). Identify whether all participating providers and organizations within the team have the legal authority to collect, use and disclose personal health information for the purposes of providing health care and for any administrative or secondary use purposes. Outline the safeguards that will be in place to ensure the protection of personal health information. Append a data flow chart. Identify whether there are any barriers or challenges to your proposed information sharing plan.

Max word count: 1500

The overall system architecture is a critical component to enabling information sharing for integrated care delivery. The East Toronto Health Partners have established an Architecture Working Group to work towards the development of an architectural vision that will help achieve full connectivity for providers and patients.

There are a number of individual tools that are, or are being, implemented that facilitate sharing of patient information across organizations. These include:

- ConnectingOntario – for sharing client record, including to primary care
- eCCP – for sharing coordinated care plans; focus on neighbourhood care
- Secure messaging – for communicating between providers, and potentially including communicating about patient clinical info
- Hospital Report Manager and eNotification – for sharing to primary care
- CHRIS – providing access to CHRIS to those organization that require it to facilitate information sharing in the community

These provincial systems serve as a foundation for an OHT architecture that leverages these provincial tools to complement the local digital ecosystem which, together, works to establish full information sharing.

Through the work of the Architecture Working Group, gaps were identified and a conceptual architecture, including data flow, was developed (included in the supplemental information).

Key points include:

1. The conceptual architecture highlights the complementary assets within the local Ontario health team ecosystem and the provincial ecosystem that will enable overall digital connectivity for ETHP.
2. The conceptual architecture contemplates a long-term future state where data exchange of clinical information is facilitated by the provincial ONE Access Gateway.

3. Data would flow from all anchor and engaged partners into the provincial electronic health record (EHR), and would be drawn out into a local population health management solution based on “registered” patient, thereby giving a full view of the patient journey.
4. A population health management solution will be implemented that will facilitate identification of risks, match patients with the appropriate care programs, and to inform clinical and planning decisions.
5. A Customer Relationship Management (CRM) tool / functionality will be implemented the specifically provides a customer profile of the citizens being served by the OHT and supports tracking and managing of the ongoing relationship with that citizen.
6. CHRIS will be leveraged heavily to provide better integration of home and community, which includes expanding access to the system by partners beyond existing LHIN home and community care staff.
7. Health Report Manager (HRM) will continue to be leveraged to facilitate information exchange with primary care.
8. A citizens’ “gateway” is being contemplated for ETHP that will leverage a national or provincial identity authentication solution to give access to a suite of tools ranging from patient portal to supports for health literacy; furthermore, the authentication solution will enable consent management for sharing of data.
9. Sunnybrook MyChart is the patient portal being implemented by anchor partners, and the architecture indicates that data should be flow to and from the ONE Access Gateway; for ETHP citizens, they will use MyChart through the citizens’ “gateway”.

An integral element of the long-term strategy for data exchange in is to leverage the provincial ConnectingOntario and ONE Access Gateway architecture. Across multiple OHTs, there is interest in reaffirming commitment to a provincial strategy to enabling data to flow into a single repository that can then be accessed by participating organizations as appropriate. Not only will this provide the most scalable solution, but it will also respect the notion of patients accessing services across OHT and from specialized institutions and programs.

Further details on other connectivity initiatives are highlighted in Section 2.3 of Appendix B.

From a privacy perspective, all anchor partners, except VHA Home HealthCare and EasT-FPN, are designated Health Information Custodians (HICs). Furthermore, all have privacy, security and cyber security frameworks in place. With the support from the province with respect to policy guidance and the rewriting of PHIPA, OHT anchor partners will adopt privacy and security standards in accordance with compliance required to ensure the protection of PHI. One of the objectives in year 1 is to develop a data sharing agreement across the partners that will articulate a commitment to harmonizing policy where appropriate and feasible, with the aim to work towards a fully integrated data sharing construct based on patient consent. A privacy working group is being developed to move this advance this thinking. Additionally, a dedicated focus will be given to data governance, ensuring the ETHP can successfully

implement a joint model of leading practice in data governance and information sharing. The work will include the completion of high-level mapping of current capabilities to enable data governance and information sharing. Ultimately, the vision is to facilitate information sharing in a manner consistent with being a seamlessly connected and integrated organization.

4.3.2. How will you digitally enable information sharing across the members of your team?

Please refer to Appendix B – Digital Health to propose your plan for digital enablement of health information sharing.

5. How will your team learn & improve?

5.1. How will participation on an Ontario Health Team help improve individual member performance or compliance issues, if any?

Identify whether any of your team members have had issues with governance, financial management, compliance with contractual performance obligations, or compliance with applicable legislation or regulation.

Where there are issues, describe whether there is a plan in place to address them. Indicate whether participation on the team will help and why. Indicate whether there will be any formal accountability structures in place between individual team members and the team as a whole for ensuring that individual performance or compliance issues are addressed.

Max word count: 500

No ETHP Anchor Partners have identified issues with governance, financial management, compliance with contractual performance obligations, or compliance with applicable legislation or regulation. As part of our shared commitment to the sustainability and success of the East Toronto OHT and our projects and particularly for our newest Anchor Partner, the EasT-FPN, the ETHP Anchor Partners will develop a financial plan.

As outlined in section 4.0, the Anchor Partners have developed a Joint Venture agreement that has contractual obligations and formal accountability structures in place to address performance or compliance issues, including language related to the process for removal of parties to the Agreement.

5.2. What is your team's approach to quality and performance improvement and continuous learning?

Ontario Health Teams are expected to pursue shared quality improvement initiatives that help to improve integrated patient care and system performance.

5.2.1. What previous experience does your team have with quality and performance improvement and continuous learning?

Describe what experience each of the members of your team have had with quality and performance improvement, including participating in improvement activities or collaboratives and how each collects and/or uses data to manage care and to improve performance. Provide examples of recent quality and performance improvement successes related to integrated care (e.g., year over year improvement on target Quality Improvement Plan indicators).

Highlight whether any members of your team have had experience leading successful

cross-sectoral or multi-organizational improvement initiatives.

Describe your members' approaches to continuous learning and improvement at all levels. Indicate whether any members of your team have had experience mentoring or coaching others at the organizational-level for quality or performance improvement or integrated care.

Identify which team members are most and least experienced in quality and performance improvement practices and whether there are any strategies planned to enhance quality focus across all member organizations/providers. Similarly, identify and describe which team members have the most and least data analytic capacity, and whether there are any strategies planned to enhance analytic capacity across all member organizations/providers.

Max word count: 1000

Five of the Anchor Partners of the ETHP (not applicable to the new EasT-FPN) are accredited with Exemplary Standing through Accreditation Canada. Providence Healthcare (Unity Health Toronto) has also achieved Stroke Distinction from Accreditation Canada.

Beginning in fall 2018, the ETHP developed a collaborative approach to quality improvement, with initial support from senior leadership at Health Quality Ontario, focused on our priority populations and initiatives to reduce hospital surge during flu season. This work reflected shared priorities across partners, and the early recognition that cross-sector partnerships better enable us to achieve our desired impact.

We also invested in enhancing local, front-line quality improvement capacity. For example, in 2018/19 an integrated team was sponsored to attend the IDEAS program, focused on reducing avoidable hospital use for women and families. In 2019, the Canadian Foundation for Healthcare Improvement (CFHI) accepted an application by a joint team across MGH, WoodGreen and VHA to the EXTRA Fellowship, for the Home 2Day model. Through the EXTRA program, we are building on Home 2Day's initial focus on COPD, to build capacity across our partners while also spreading and scaling the program to support patients with other chronic diseases (e.g. Pneumonia, CHF, Diabetes). This supports our shared commitment to quality and performance improvement for a core program serving our Seniors with Chronic Disease and Caregiver population, focuses our spread efforts on key change initiatives, and accelerates the impact of this initiative on population health outcomes.

Building on our foundational commitment to quality, the East Toronto Digital Connectivity Approach also brings a clear focus on establishing an intelligent, learning system to predict needs, provide evidence for planning, and achieve operational efficiencies. Primary Care providers are a key partner in measurement, quality

improvement and continuous learning, and will have a strong voice in determining the measurement approaches and digital tools we use to support quality and connectivity within the ETHP.

Additional examples of our collaboration on quality improvement for Year 1 include:
• We have commitment from all ETHP hospital, primary care (CHCs and FHTs), long-term care, and home care organizations that currently have annual Quality Improvement Plans to advance the submission of an integrated/collaborative QIP for March 2020. In fall 2019, we will be hosting a stakeholder engagement process across the participating organizations and patients and caregivers to identify a process for selecting shared measures and establishing targets.
• To support performance improvement activities, four of the ETHP Anchor Partners have signed an agreement with the Registered Nurses Association of Ontario (RNAO), to become a 'collaborative' Best Practice Spotlight Organization (BPSO). Currently VHA and Unity Health Toronto are BPSO organizations, but we see a benefit in taking on best practices from the perspective of integrated care across the Anchor Partners as well as our broader partnership. We would be one of only four OHT candidates who are moving forward with RNAO at this time to use their best practices to inform improvements to care across our partner organizations. The focus in year one will be engaging interprofessional teams, enhancing evidence-based practice and decision-making cultures with a focus (year two) on implementing care transition and person and family centred care.

5.2.2. How does your team currently use digital health tools and information to drive quality and performance improvement?

Please refer to Appendix B – Digital Health to provide information on how your team will leverage digital health tools for improvement.

5.3. How does your team use patient input to change practice?

Ontario Health Teams must have a demonstrable track record of meaningful patient, family, and caregiver engagement and partnership activities. Describe the approaches the members of your team currently take to work with patient, family, and caregiver partners and explain how this information gets embedded into strategic, policy, or operational aspects of your care, with examples.

Do any members of your team have experience working with patients to redesign care pathways?

Identify which of your members have patient relations processes in place and provide examples of how feedback obtained from these processes have been used for quality improvement and practice change. Describe whether any members of the team measure patient experience and whether the resulting data is used to improve.

Max word count: 500

The ETHP Anchor Partners each have a track record of meaningful patient, family and caregiver engagement, including both collaboration and co-design. All partners have patient relations processes with different means to collect complaints and compliments and use them to improve quality and patient and staff safety. Examples of how we use patient input to improve practice include:

- South Riverdale CHC has taken a proactive approach to engage the wider community regarding the development of services, such as the supervised consumption services. Inviting the community into its space, answering questions and engaging in dialogue to address concerns and build relationships.
- From its patient survey responses Michael Garron Hospital learned that patients often did not know how to manage their care once they left the hospital. MGH worked with over 150 patients to customize Patient Oriented Discharge Summaries (PODS) for different surgical groups, using health literacy principles, and developed a process for automated post transition phone calls. As a result, patient knowledge increased by 36% as did the number of patients who would recommend MGH to family and friends by 51%.
- WoodGreen successfully engaged clients in program improvement for the Walk-in Counselling Quality Improvement initiative, which was co-led by a group of clients who were also service participants. The project led to improved intake and wait time management for this service and was featured at a national conference.
- EasT-FPN: East Toronto Health Link and SETFHT have active Patient and Community Advisory Councils influencing strategic and operational aspects of care. Patient co-design is an important quality improvement approach that the EasT-FPN will incorporate and contribute towards the OHT. Members of the EasT-FPN have training in patient co-design and teach it at the university, and SETFHT was one of the first University of Toronto FHTs to design a patient experience survey ahead of HQO and AFHTO rolling one out on a larger provincial scale. All family practice offices have Patient Care Resolution Policies and Processes embedded in their ongoing operations including posted policies online.
- VHA developed three steering committees which included clients, caregivers, staff and providers. Each Steering Committee was tasked to create a five-year roadmap to identify gaps in areas of care pathways, education and operations. Examples include redesigning access for palliative/end-of-life clients and caregivers such as a new co-designed website, designated phone line access, and a quality survey designed by the client and family partners. VHA also co-designed VHA PlayDate with parents of children with complex medical needs to provide play opportunities and parental respite.
- Patient and caregivers provided their ideas alongside the Providence Healthcare (Unity Health Toronto) clinical leadership team in a series of design planning sessions to redesign rehabilitation pathways and expanded access to outpatient rehabilitation. In addition, Providence partnered with patients and caregivers to design their Falls Prevention Clinic, serving the vulnerable geriatric population in our community.

5.4. How does your team use community input to change practice?

Describe whether the members of your team formally or informally engage with the broader community (including municipalities), and whether the outcome of engagement activities influence the strategic, policy, or operational aspects of your care.

Max word count: 500

Community engagement in the design of integrated health and social care in East Toronto is core to the continuing advancement of the ETHP's vision. The ETHP have both individual and collective experience working with our communities to improve care.

ETHP has developed a Community Engagement Framework with patient representatives as partners. The Framework is a best practice guideline for current and future engagement activities within the OHT planning context, and reflects unique contributions and perspectives of patients, community members and providers. Patient representatives were engaged in a joint working group with representation from the East and Downtown East OHTs. This framework will be the foundation for our ongoing engagement activities.

In Year 1, we have identified specific examples in this application of using community engagement to improve care, such as our planned substance use and health hub in the Oakridge neighbourhood to address concerns from that community about the lack of access to services and supports for the local population. As outlined in section 3.2, we are also partnering with the City of Toronto to implement phase one of the Integrated Service Model for Seniors Buildings in the Toronto Community Housing portfolio in 18 seniors' buildings in East Toronto.

Individually, we have also engaged with our communities to improve care and services, for example:

o South Riverdale CHC engages its broader community members and partners including the City of Toronto (Social Development Finance and Administration, Public Health) and academic research partners to inform population health approaches and initiatives (examples Refugee Response, sexually transmitted disease responses/programs, Drug Strategy, Chronic Disease programming, neighbourhood level engagement/planning for service delivery, maternal newborn health)

o Michael Garron Hospital has co-designed several programs with Indigenous Communities including an Aboriginal Healing Program for Withdrawal Management. In August 2019, members of the Aboriginal Healing Program and members of MGH celebrated the opening of a Sweat Lodge on the hospital grounds.

o Many of our family practices have long relationships with the City of Toronto Public Health Department in the areas of patient safety, immunization and prevention programs.

o Health Access Thorncliffe Park (HATP): Community voices identified the need

for comprehensive primary care services to be expanded in Thorncliffe Park (TCLHIN Gap analysis). The model design for HATP has been community led, resulting from the partnership of Flemingdon Health Centre (FHC) and The Neighbourhood Organization (TNO), a local agency with a range of social services supports. HATP utilizes Community Ambassadors or Champions from the community to help with Health education and promotion initiatives. With the development of the Thorncliffe Park Community Hub, there is an intentional inclusion of community in the governance of the hub. HATP engages the community through a variety of channels and forums (for example: Community Crisis Response Table, Landlord-Tenant associations, Elder Person Consortium, Flemingdon-Thorncliffe Park Interagency Committee) to ensure that the community is aware and engaged in the work HATP is doing.

5.5. What is your team's capacity to manage cross-provider funding and understand health care spending?

Please describe whether your team has any experience in managing cross-provider funding for integrated care (e.g., bundled care). Have any members of your team ever pooled financial resources to advance integrated care (e.g., jointly resourcing FTEs to support care coordination)? Does your team have any experience tracking patient costs or health care spending across different sectors?

Max word count: 500

The ETHP have a number of established a number of clinical and fiscal accountability relationships across our 'Network of Networks', which contribute to advancing the Quadruple Aim for our communities. Examples include:

• Home 2Day: Michael Garron Hospital (MGH), WoodGreen and VHA partner to deliver the 'hospital at home' model, delivering seamless transitions and integrated care for COPD patients across hospital and home settings. Through an integrated care pathway with shared clinical and fiscal accountability, the partners identified opportunities to reduce costs and improve patient experience, saving approximately $1,500 per patient for the same clinical outcomes, while also reducing hospital length of stay to help address hallway medicine pressures in the system.

• Participation in Bundled Care pathways: MGH and Providence Healthcare (Unity Health Toronto) partner on the Hip and Knee Bundled Care pathway through a defined MOU, supporting all post-surgical inpatient and day program care for patients; other surgical pathways are in development with a focus on reducing total costs, while maintaining patient outcomes and experience.

• Bariatric Centre of Excellence –MGH and Providence partner to improve care to bariatric patients across East Toronto, including providing local assessment,

education and treatment services.
• Health Links: The East and Don Valley Greenwood Health Links brought together local physicians with community providers and hospitals to improve care transitions and access to coordinated care and community services.
• SCOPE: Family Practice Physicians in East Toronto have established the SCOPE program with MGH. SCOPE is a virtual interprofessional health team that supports primary care providers through a single point of access.
• Community Surge: In 2018, MGH reallocated $1.5 M of surge funding to support surge across our community partners and assist with reducing inpatient and emergency department pressures. Community surge investments last year included funding expanded levels of support in home and community care, extending hours of service in primary care clinics, and increasing access to flu vaccinations in the community. Based on the success of our first round of community surge investments, in 2019, MGH is increasing our community surge investments to $1.8 M. This effort included over 10 engaged partners in 2018/19 and expanded to include all 30+ engaged partners in the planning for the 2019/20 surge.
• Shared Staffing Resources: In 2019, MGH, WoodGreen and South Riverdale CHC collaborated on recruitment of a shared Director of Mental Health and Addictions Services. Funding and oversight for this role is shared by the three partner organizations. The Director works across all three organizations to better coordinate and integrate mental health and addictions services. In addition, to support the development of our OHT application, several ETHP partners contributed in-kind staffing resources to create a ‘virtual’ project team to support project management, application development, stakeholder engagement, meeting logistics, etc.

Across these initiatives, and more broadly for the ETHP, the CEO leadership of our anchor partners agreed in fall 2018 that Michael Garron Hospital would become a primary fund holder for the collective. At maturity, we will shift to joint funding and accountability as the ETHP.

6. Implementation Planning and Risk Analysis

6.1. What is your implementation plan?

How will you operationalize the care redesign priorities you identified in Section 3? Please describe your proposed 30, 60, 90 day and 6 month plans. Identify the milestones will you use to determine whether your implementation is on track.

Max word count: 1500

The ETHP have a number of priorities for Year 1 including:

o Launching a process to develop a strategic plan for ETHP that engages our whole community, partners, patients, and caregivers in identifying our long-term vision and strategic priorities for the redesign of care and development of an integrated system of care in East Toronto. We will also use our strategy development process to help advance key aspects of our work that need to be addressed such as identifying next steps in our governance model and stronger engagement with our indigenous communities.
o Advancing our governance and leadership model by creating a Governance Committee that engages Board members of the Anchor Partners, engaging patients and caregivers at our governance table, establishing a memorandum of understanding with defined accountabilities for our engaged partners and creating a leadership structure to support the work of the ETHP
o Supporting the development of our family practice network by working closely with the East Toronto Family Practice Network, including drafting a financial plan to enable EasT-FPN to engage with local family physicians to advance shared priorities for integrated care.
o Advancing our Year 1 priorities for redesigning care across our priority populations and planning for our Year 2 priorities.
o Supporting additional change management across our teams, including new ways of working together and delivering care, such as expansion of our Home 2Day program. We will also support teams as we implement changes to staff roles and functions, for example transitioning LHIN Home and Community Care staff to the ETHP and supporting staff to work to their full scope of practice as we redesign care in our hospitals and in the community.
o WoodGreen is leading a process to better integrate the delivery of Community Support Services within the geography to increase our Ontario' Health Team's capacity to serve the attributed population. The process will focus on finding efficiencies and maximizing existing resources by improving financial accountability and performance oversight, introducing centralized referral and intake processes and implementing quality standards across the geography. Initial functional centres slated for improvement will be Meals on Wheels, Congregate Dining, Adult Day Programs and Case Management, but this initiative will be expanded to include all service areas.

While the ETHP is submitting this application to become one of Ontario's first health teams, our actual work to advance integration of health and social care in East Toronto has already begun. Section 2.4 described our long history of partnership as

well as our current tests of change to deliver integrated care. As our work has already started, we have outlined our next round of key milestones below:

October – December 2019:
o Confirm dedicated leadership and project support for the ongoing work of the ETHP (October)
o Launch our Best Practice guidelines with RNAO and establish a Steering Committee to guide this work (October)
o Work with our engaged and supporting partners across our priority populations as well as our home care design and digital health teams to confirm our work plans and deliverables (October-November)
o Develop a financial plan to support the sustainability and success of the ETHP and particularly for its newest Anchor Partner, the East-FPN (October-November)
o Launch our community surge initiatives, including establishing MOUs with multiple community partners (October – November)
o Meet with our engaged partners to identify key components of a Memorandum of Understanding with the ETHP (October – November)
o Develop a proposed approach to embed LHIN Home and Community Care staff within the ETHP (October – November)
o Put out a call for members to join a Joint Patient and Caregiver Advisory Committee across the Anchor Partners and work with them to identify representation at the governance level (October - November)
o Convene a meeting of all East Toronto organizations that currently submit Quality Improvement Plans to establish agreement on next steps for a collaborative / integrated QIP to be submitted in March 2020 (October – November)
o Co-locate MGH transition staff and LHIN Hospital Care Coordinators into a shared space (November)
o Launch a communications strategy to help our community begin to understand the ETHP brand, what we are trying to achieve, and how they can become engaged with us (November)
o Establish a Governance Committee for ETHP to look at next steps in our Governance model as well as a plan for shared Governance education (November-December)
o Establish baseline data and targets for our key performance metrics (November-December)
o Finalize our digital architecture plan (December)

January – March 2020:
o Outline a process for engaging with our community and partners in developing a strategic plan for ETHP
o Beginning planning for our Year 2 priorities
o Advance specific Digital Plan priorities, including:
- Create a common privacy and security framework across the ETHP
- Implement a plan to scale our secure messaging pilot
- Implement MyChart at two additional ETHP sites
o Launch our strategic planning process

o Evaluate the outcomes of our community surge activities

6.2. What is your change management plan?

Please describe your change management strategy. What change management processes and activities will you put in place before and during implementation? Include approaches for change management with primary care providers, and how you propose to leverage clinician leaders in helping their peers to embrace and embed change.

Max word count: 1000

Over the last two years, the ETHP has been working with patients, families, caregivers, community partners and others to design a more integrated system of care in East Toronto. We have used the Quadruple Aim to support our change approach by ensuring that we balance a focus on experience and engagement of patients, caregivers and front-line staff, improvements targeted at population health and the broader social determinants of health and improving the value of health system investments.

Our change efforts are further guided by the Implementation Framework for Integrated Care developed by Goodwin, 2015, 2017; Lewis and Goodwin, 2017.

Key issues for success include:
☐A sound and objective understanding of health needs of a populations and why integrated care will add value to people's health and wellbeing;
☐A shared vision with a common set of objectives;
☐New ways of working with joint accountability for outcomes and mutual gain;
☐Relationship-building and service innovation comes before structural reform
☐An open and transparent learning system

Over the last two years, the ETHP moved through the first two stages of change management for our priority populations focusing on diagnosis/assessment and analysis and design, including building our partnerships, identifying shared goals, building support for change and developing capacity for collaboration. Over the last few months as we prepared for our OHT application, we have started to create our implementation plan, including identifying our Year 1 priority actions.

We believe our ability to move successfully through all phases of the change management cycle to full implementation, evaluation and learning has already been demonstrated by the previous collaboration successes described in our application, including but not limited to the success of our Home 2Day program, hip and knee bundled care pathway, Bariatric Centre of Excellence, community surge implementation in 2018 (which we are now expanding in 2019), neighbourhood care teams in Thorncliffe Park and Taylor-Massey, and the multitude of examples from our Solutions network.

Important next steps in our change management plan include:

o Confirm dedicated ETHP shared leadership and project support, as well as ongoing contribution of in-kind staffing resources from across the partners to support the work as a 'virtual' project team
o Work across the ETHP anchor partners to create a financial plan that will support and sustain the momentum of our partnership, including the work of the EasT-FPN to engage family physicians across East Toronto in the changes needed to advance integrated care
o Continue to build and strengthen relationships between the Anchor Partners and Engaged and Supporting Partners by coming together to reconfirm our commitment and plans for working together to advance our Year 1 priorities
o Continue with opportunities to educate our teams on integrated care, co-design, health equity and other important foundational elements for building a population health approach to caring for our whole community
o Establish a shared Governance Committee to advance the governance model for the ETHP, including joint governance education to build our knowledge and understanding of integrated care and how we will work together to achieve our vision
o Increase our communications activity across all the ETHP organizations in East Toronto as well as with our community to share our progress and engage people in our work
o Continue to evaluate and share results of our integration initiatives such as our expanded Home 2Day program and community surge activities to build confidence in our ability to work together and change how care is organized and delivered
o Work with other emerging Ontario Health Teams to share knowledge and resources, and advance shared regional priorities
o Launch a strategic planning process that engages our whole community in designing the future of integrated care and population health in East Toronto

6.3. How will you maintain care levels of care for patients who are not part of your Year 1 population?

Indicate how you will ensure continuity of care and maintain access and high-quality care for both your Year 1 patients and those patients who seek or receive care from members of your team but who may not be part of your Year 1 target population.

Max word count: 500

Our implementation plan does not include changing capacity or services to any of our existing populations. All our East Toronto populations not included as part of our Year 1 priorities can expect the same access, levels of care, and services that they receive now.

6.4. Have you identified any systemic barriers or facilitators to change?

Identify existing structural or systemic barriers (e.g., legislative, regulatory, policy, funding) that may impede your team's ability to successfully implement your care redesign plans or the Ontario Health Team model more broadly. *This response is intended as information for the Ministry and is not evaluated.*

Max word count: 1000

The ETHP is fully committed to advancing integrated care and shifting to a population health focus in East Toronto, however we have identified a number of systemic barriers to change that are related to funding, legislation, home and community care, and digital systems. We would be pleased to engage in further discussion with the Ministry of Health and Long-Term care about the barriers/enablers we have identified thus far, including:

☐The need for dedicated funding to support local OHT advancement such as:
- compensation for physicians to engage in planning, design and evaluation of our activities, including sustainable funding for the EasT-FPN
- approval for additional FHO positions in East Toronto
- providing support for project and administration of local OHT integration work as this cannot be managed within existing staffing resources
- investment in critical digital solutions

☐Addressing legislative and policy barriers, including:
- PSLRTA - our labour legislation needs to be reviewed and updated to accommodate the emergence of integrated systems of care by enabling us to shift staffing resources across organizations and sectors to create a 'one team' approach to supporting patients and caregivers in the community
- PHIPA – our privacy legislation needs to enable better sharing of information between providers that are part of the circle of care, broaden the circle of care to include health and social services such as supportive housing, and to include home care service providers as Health Information Custodians
- LHSIA – we need the government to accelerate changes/repeal the LHIN legislation in order to enable the movement of home care staffing and resources to the OHTs
- Children and Youth – we need legislation that better supports youth, such that when individuals turn 18 years old they will continue to have support under the funding structure for youth mental health and addictions community services, at least up to the age of 24
- Long-Term Care Legislation – reviewing and updating the existing Long-Term Care (LTC) legislation that provides substantial limitations on the role of LTC, including expansion and support for community-based care models attached to long-term care, ability to prioritize local residents for long-term care homes, and addressing compliance provisions that restrict flexibility to customize care for residents. In addition, we would like to enable patients to transition as quickly as possible to the 'right place of care' by supporting patients to move to the first available LTC bed while they wait for their preferred bed to become available.

☐Modernizing Home and Community Care, including:
- LHIN-SPO contracts – need to identify a process for establishing accountability agreements between home care service providers and the OHT, including financial/funding model that shifts away from fee-for-service

payments and enables OHTs to establish financial and accountability agreements similar to other Health Service Providers
- Addressing personal support worker capacity by addressing issues such as more stable employment models, wage disparity, high turnover rates, and worker dissatisfaction
- Supporting a human resources strategy for home and community care to address capacity and wage disparity across sectors

• Address gaps in current data exchange capabilities provincially, including the need to further advance the provincial electronic health record (EHR) that will facilitate information flow for patients that are both part of multi-organizational OHTs as well those that move across future OHT boundaries

6.5. What non-financial resources or supports would your team find most helpful?

Please identify what centralized resources or supports would most help your team deliver on its Year 1 implementation plan and meet the Year 1 expectations set out in the Guidance Document. *This response is intended as information for the Ministry and is not evaluated.*

Max word count: 1000

The ETHP are optimistic that we can advance integrated care, but also recognize the important role of the Ministry in supporting change management and accelerating several system-level funding and policy domains:
- Support for Family Practice Network development and sustainability, toward our efforts in developing a 'first in Ontario' family physician network, and policy support to enable better collaboration and engagement of family physicians
- Integration of home care through legislative, regulatory, and policy changes that evolve the role for home care service providers, enable us to shift LHIN home care staff to the ETHP, and address a future state for service provider contracts
- Facilitating service transfers and the integration of health service providers to streamline existing agencies, enabling service capacity optimization across the continuum of community and social services.
- Support open access and investments in digital and virtual care platforms, including opening the home care CHRIS system to all for use as a shared record, and supporting targeted investments to deliver digital tools across ETHP (e.g. service and care navigation tools, EMR deployment and integration, My Chart for patients).
- Address additional legislative barriers to integration, including enabling all ETHP to be a single Health Information Custodian under PHIPPA, changing PSLRTA to support health human resources integration and wage harmonization, and changing various health service acts to enable pooled funding.
- Provide ongoing data on health equity, by continuing the important work established by TC LHIN for ongoing collection and analysis of self-reported patient information on cultural identity, ethnicity, religion, sexual orientation, and other personal information that will enables the OHTs to identify service patterns and equity gaps for specific populations.

- Increased access to population-health data, by going beyond the data packages to provide ETHP with Access to the 'raw' population-based data from MOHLTC so we can access our own population data at the neighbourhood-level and combine it with asset maps and other local information - Support local OHT planning tables particularly for adjacent OHTS - Provincial communications guidelines around branding and communications to assist local OHTs to align with the government's communications strategy

6.6. Risk analysis

Please describe any risks and contingencies you have identified regarding the development and implementation of your proposed Ontario Health Team. Describe whether you foresee any potential issues in achieving your care redesign priorities/implementation plan or in meeting any of the Year 1 Expectations for Ontario Health Team Candidates set out in the Guidance Document. Please describe any mitigation strategies you plan to put in place to address identified risks.

As part of your response, please categorize the risks you've identified according to the following model of risk categories and sub-categories:

Patient Care Risks • Scope of practice/professional regulation • Quality/patient safety • Other	**Resource Risks** • Human resources • Financial • Information & technology • Other
Compliance Risks • Legislative (including privacy) • Regulatory • Other	**Partnership Risks** • Governance • Community support • Patient engagement • Other

Risk Category	Risk Sub-Category	Description of Risk	Risk Mitigation Plan
See supplementary Excel spreadsheet			

6.7. Additional comments

Is there any other information pertinent to this application that you would like to add?

Max word count: 500 In partnership with those who receive care and those who provide care in East Toronto, the East Toronto Health Partners (ETHP) are pleased to submit our full

application to become one of Ontario's first Health Teams. Our vision is to work with our community to co-design 'A System without Discharges': A seamless continuum of care focused on population health, with programs tailored to our 21 local neighbourhoods and communities. The Province's support for the Ontario Health Team model has provided a substantial opportunity for East Toronto to spread and scale the work we have already started towards building an integrated system of care co-designed with patients and caregivers, as well as creating new platforms for change and innovation across all our provider partners. In our application we have identified specific actions the provincial government can take to help us accelerate our efforts (including addressing policy barriers, providing resources and funding support in specific areas, and supporting provincial digital solutions), which we would be pleased to discuss further. We are excited to submit our full application and we look forward to working with the Ministry of Health and Long-Term Care to accelerate our work. The ETHP are confident that we are ready to be one of the province's first Ontario Health Teams.

7. Membership Approval

Please have every **member** of your team sign this application. For organizations, board chair sign-off is required.

By signing this section, you indicate that you have taken appropriate steps to ensure that the content of this application is accurate and complete.

Team Member	
Name	
Position	
Organization (where applicable)	
Signature	
Date	
Please repeat signature lines as necessary (See supplementary Excel spreadsheet)	

APPENDIX A: Home & Community Care

Ontario Health Teams will help to modernize home and community care services, so patients can live at home longer, return home more quickly from hospital, or delay or avoid the need for admission to a hospital or a long-term care home.

In this section, you are asked to outline a long-term vision for re-designed home and community care model and a short-term action plan with immediate priorities. Your team is encouraged to consider how you will improve the patient and provider experience, better integrate home and community care with other parts of the health care system and improve the efficiency of home and community care delivery. For Year 1, you are asked to propose a plan for transition of home and community care responsibilities to your Ontario Health Team.

Your proposal should demonstrate how you plan to re-imagine and innovate in home and community care delivery, while ensuring efficient use of resources. Your team's proposal will help the Ministry understand how to better support innovative approaches to home care. The Ministry is exploring potential legislative, regulatory and policy changes to modernize the home care sector so that innovative care delivery models focused on quality can spread throughout the province.

Responses provided in this section will be evaluated based on how well your team understands the home care needs of your Year 1 and maturity populations and opportunities for improvement and how well your proposed plan aligns with the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management.

A.1. What is your team's long-term vision for the design and delivery of home and community care?

Describe your long-term vision for how you will modernize and better integrate home and community care taking into consideration local population needs and local challenges in home and community care.

Highlight proposals to strengthen innovative service delivery, increase accountability for performance, and support efficient and integrated service delivery.

Max word count: 1500

The East Toronto Health Partners are committed to supporting the design and implementation of an integrated system of care in our local community that includes redesigning how home care is organized and delivered. We will leverage the

knowledge and skills of our patients, caregivers, community and partners to inform the future of home and community care delivery and will focus on these key principles as the future is being formed:

1. We will co-design and build interconnected systems of care in local neighbourhoods with patients, caregivers, home and community care providers, primary care, acute care, community support services, and other partners. These interprofessional, cross-sectoral teams will simplify and improve access, navigation, coordination and delivery of home and community care, as well as access to acute and specialty care. We will also improve efficiency and effectiveness of care by reducing duplication, streamlining administrative processes, enabling staff to work to their full scope, and facilitating timely communication across all members of the care team, including patients and families.
2. We will ensure that care coordination and system navigation will be key functions in the future health system to support easier access for patients, caregivers and providers to the services they need
3. We will innovate and implement tests of change to help people (patients, caregivers, physicians, and staff from our organizations) understand how we will transition to new ways of working together that will define our future system

In September 2019, the East Toronto Health Partners hosted an initial planning session with clients/caregivers (with experience of home care), primary care, family physicians, home care service providers, and Toronto Central LHIN home and community care. The agenda for the session was co-designed with clients and caregivers, who launched the discussion by identifying the core aspects of system redesign that would be important to them, including:

- Care is connected and easy to access
- Care is focused on what's most important to clients, caregivers and families
- The level and type of care meets our needs
- We (clients, caregivers, physicians, providers) are all part of the care team
- The needs and wellness of caregivers are addressed

Our principles and the core aspects of system redesign that are important to clients, caregivers, and families helped ground us as we conceptualized a future state. Our planned redesign of home and community care within an integrated system is based on evolving our existing neighbourhood care model and scaling it to all our East Toronto neighbourhoods as depicted in the graphic in the supplemental information.

Unlike our current siloed model of care, through our neighbourhood-based model of integrated care, people will experience one local system that provides simple access to health services and social supports, navigation / coordination if unable to self-navigate, inter-professional/interorganizational teams, and streamlined communication of health and social care providers. This model focuses on simplifying the system for patients and frontline staff, maximizing current system investments and enhancing efficiency and effectiveness. Key enablers of this model of care are:

• A simplified model for hospital to community transitions, with established care pathways that support patients to move easily from care in hospital to care delivered by their local neighbourhood care team
• Integrated, neighbourhood-based care teams, that align interprofessional teams with primary care. With Neighbourhood hub agencies (including large primary care practices – FHTs, clinics, CHCs and CSS organizations) that will play a supporting role to connect primary care, home care and other local services.
• Care Coordinator/Navigators aligned to neighbourhoods / specific geographies using existing staffing resources from LHIN home and community care, home care service providers, primary care and family physicians, CSS, MH&A programs, and other organizations that currently provide these services
• Community organizations aligned to neighbourhoods / specific geographies
• Home care service providers aligned to neighbourhoods / specific geographies within a model of care that enables us to expand direct referrals to home care service providers and improve communication with primary care, family physicians and other community-based services. This will be enabled by direct referral and new funding models that shift away from fee-for-service payments
• Standardized performance frameworks and quality standards with accountability to the OHT leadership structure
• Access to OHT-wide supports including, but not limited to; acute care, specialty care, 24/7 call centre support services for patients and caregivers, virtual care and remote monitoring
• Digital communications and integrated information systems to support care teams, patients and caregivers with real-time access to patient health information and care plans that address the full social determinants of health.

At maturity, local neighbourhood care teams will be responsible for home and community care functions for their local populations including:
• Intake, assessment and coordinated care planning
• Promoting self-management, as well as health and wellness supports
• Determining levels of services
• Case management, system navigation for health and social services
• Care delivery and
• Assessing and determining eligibility for long-term care, supportive housing and other residential services

There are three existing tests of change in East Toronto that we will build on to develop our neighbourhood care teams:
1. In Thorncliffe Park we have developed a dedicated interprofessional/ interorganizational team with local primary care that includes dedicated staff from home care service providers, a CSS agency, and LHIN home and community care. This team provides wrap-around support for frail seniors 75+ with multiple chronic health conditions who are homebound. The services include caregiver support and respite, home care, specialized dementia care, and address the social determinants of health for individuals including financial empowerment, housing, nutrition, settlement and culturally-sensitive case management and service supports.

2. We have developed an interprofessional care team that wraps around primary care practices serving the neighbourhoods of Taylor-Massey, Victoria Village, and Oakridge. The team includes LHIN Care Coordinators and other community partners and is designed to address the social determinants of health for our immigrant and newcomer populations.
3. In the SouthEast Family Health Team, there are two embedded LHIN care coordinators who act as a bridge between primary care and home care services for homebound patients.

Hospital Transitions to Neighbourhood-based Integrated Service Delivery:
In this new model of care, care will be redesigned for both existing clients receiving services in the community and for new clients who require community services after leaving hospital.

For existing clients served by interprofessional, neighbourhood care teams (NCT), the client's local neighbourhood care team would be electronically notified if their client is admitted to an inpatient unit at Michael Garron Hospital or Providence Healthcare (Unity Health Toronto). The NCT would then be responsible for working with the patient, caregivers, and hospital transitions team on a plan to return home and for reviewing and updating the care plan to ensure the necessary services are in place once the client leaves the hospital.

For new clients, particularly patients with complex and rising risks/needs, we will develop an integrated transition team within the hospital from existing staffing resources that will support the patient journey from hospital admission to transition home and will engage with the local NCT to prepare for the client's return home.

Service Provider Service Delivery:
(Note additional consultation is required to further develop this section, including discussion with the Ministry on policy enablers)

Our Neighbourhood Care model envisions geographic alignment of home care service providers within our ETHP boundaries and testing new funding models including exploring functional budgets (as exists for other health service providers) based on the service population. Home care service providers would be fully accountable for home care service delivery for their local populations, including but not limited to: participating in shared assessments and developing home care service plans with clients, caregivers and the NCT care team; determining the scheduling of services according to the needs of patients/families; and meeting quality and performance standards established with the OHT.

Regional and Provincial supports:
The ETHP understand that while much of the primary care/home and community care/CSS/other services can be integrated at a neighbourhood-level, there are other supports that need to be confirmed at an OHT-wide, regional and provincial level in order to optimize use of scarce resources and/or optimize economies of scale. These

overarching supports could include, for example, an ETHP 24/7 phone access line for local services or this may be offered through a regional partnership. Confirmation for how these supports will be organized and delivered are not finalized and further discussion is required with regional partners and the Ministry to determine appropriate options; however, our intent is to build 24/7 access through an existing line (such as the 310-CCAC line that is now run by the LHINs, Seniors Crisis Line, or other line to be determined) with regional (or potentially provincial) access.

A.2. What is your team's short-term action plan for improving home and community care in Year 1?

Identify your top priorities for home and community care in your first 12 months of operation.

- What proportion of your Year 1 population do you anticipate will require home care? For this proportion of patients, describe patient characteristics, needs and level of complexity.
- Describe how you will innovate in the delivery of care to improve the delivery of home and community care to achieve your Ontario Health Team quadruple aim objectives.
- Outline a proposed approach for how you will manage patient intake, assess patient need, and deliver services as part of an integrated model of care. If relevant use the **optional** table below to describe the delivery model.

Role/Function	**Organization**	**Delivery Model** (What type of provider (dedicated home care care coordinator, FHT allied health professional, contracted sevice provider nurse, etc) will be providing the service and how (in-person in a hospital, virtually, in the home, etc.)
Managing intake		
Developing clinical treatment/care plans		
Delivering services to patients		
Add functions where relevant		
See supplementary Excel spreadsheet		

Max word count: 1000

In consideration of our Year 1 priority populations, the highest user group for home and community care services will be our seniors with chronic disease population, all of whom may access to home and community care services; approximately 8,000 clients per year.

For our mental health populations, including Youth and Adults with needs related to substance use, the need for traditional 'home care' services will be limited, although supports such as personal support and other services will be available to adults who need these services. Other community-based services ranging from extreme cleaning to case management and counselling services will be fully available to this client population.

Our year 1 priorities for home and community care include:

- Evolving our existing inter-professional neighbourhood models in Thorncliffe Park and Taylor-Massey towards the longer-term strategy outlined in the previous sections and testing how the range of home and community care functions (intake, assessment, care planning, coordination of services and care delivery) can be redesigned within a broader team.
- Expanding our 'Home 2Day' program that was established in 2018 to transition COPD inpatients home with enhanced home care services from WoodGreen and VHA to include other patient populations including individuals with Community Acquired Pneumonia (Fall 2019), Congestive Heart Failure (Spring 2020) and select post-surgery transitions home (Spring 2020).
- Expanding our integrated Neighbourhood Care Team model, including primary care and wrap-around inter-professional community services, to other neighbourhoods, including other family physician practices and community-based service providers. This will be done in partnership with the new EasT-FPN.
- Working with Toronto Community Housing Corporation to create integrated care in their 18 designated seniors' buildings that will bring together community-based health and social services to provide better support for lower-income seniors.
- Embedding LHIN-based home and community care staff in ETHP (as described in the next section) and maintaining stability of care to all existing home care populations in Year 1 while we test new models of care.
- Creating an integrated patient navigation and transition function within Michael Garron Hospital and Providence Healthcare (Unity Health Toronto) for complex/high needs seniors. This integrated team would be created with existing hospital and LHIN staff, and would include sharing the assessment, intake, eligibility, navigation, care planning, and service ordering functions across the new integrated team.
- Creating a strategy and roadmap for our mature neighbourhood care team model through a co-design process with patients, caregivers, home care service providers, LHIN home and community care staff, primary care, family physicians, CSS, and other community partners
- Ensuring that every 'home-bound' frail senior has access to home-based primary care, no matter where they live in East Toronto.

- WoodGreen is leading a process to integrate the delivery of Community Support Services and Community Mental Health Services within the geography to increase our Ontario' Health Team's capacity to serve the attributed population. The process will focus on finding efficiencies and maximizing existing resources by improving financial accountability and performance oversight, introducing centralized referral and intake processes and implementing quality standards across the geography. Initial functional centres slated for improvement will be Meals on Wheels, Congregate Dining, Adult Day Programs and Case Management, but this initiative will be expanded to include all service areas.

A.3. How do you propose to transition home and community care responsibilities?

Please describe you proposed plan for transiting home and community care resources to your Ontario Health Team in Year 1, such as care coordination resources, digital assets, programs, and local knowledge and expertise.

Max word count: 1000

The ETHP Anchor Partners have initiated discussions with Toronto Central LHIN leaders about the critical role and functions of home and community care and its importance in supporting system navigation, care coordination and integrated team-based care in East Toronto.

We intend to embed the roles and functions of home and community care within the ETHP Anchor Partners. It is important to note that any transition of resources needs to be thoughtfully planned and executed in the least disruptive way to patients, families, and staff alike. We recognize the importance of working with the Toronto Central LHIN to ensure roles and functions continue to be provided and resourced as we redesign our models of care.

Extensive work has already been done by the Anchor Partners to outline best practices for integrated team-based care coordination and case management for the seniors with chronic disease client population - one of our Year 1 priority populations. We are confident that the transition will be seamless for these (and other home care) clients, and that this new service model will benefit them and their caregivers, through better communication between providers, more equitable resource allocation and more effective team-based case management. Previous analyses of the this population pointed to an ongoing need for case management that included ongoing coordination of care and care planning, caregiver support, warm transitions to health and non-health services, accompaniment to appointments, monitoring of outcomes, supportive counselling for both the client and their family/caregiver and hands-on assistance with accessing resources. Embedding the functions of LHIN home and community care in the ETHP will enable a better level of service for clients in our region who require these types of supports and will help ensure that they continue to be supported safely and comfortably in their homes and in the community.

The LHIN home care staff are recognized by the ETHP for their knowledge and expertise of local resources, existing partnerships, and skills related to health care navigation, assessments, and care planning. For existing community-based staff, our plan is to embed these resources into our neighbourhood care model over time, aligning Care Coordination staff with the development of integrated care with primary care, home care, community support services, and service providers. The ETHP Anchor Partners and several of our primary care practices have a long history of building an infrastructure for service integration with Toronto Central LHIN Home and Community, which has included joint case conferencing, co-location of staff, data sharing, common assessment tools and joint training initiatives.

Embedded in neighbourhoods, Care Coordinators already work as part of an integrated team with community partners, home care service providers, and Primary Care, to support patients and their caregivers to be cared for safely in their homes. In addition to supporting seamless transition between hospital and home, Care Coordinators also support patients as their needs change by navigating clients to environments that can support appropriate levels of care (e.g., long-term care). This existing model will help us build towards our expanded vision for a more integrated model of home care, community care and primary care in neighbourhoods as outlined in section A.1.

For hospital-based Care Coordinators, we are planning an integrated patient navigation and transition function within Michael Garron Hospital and Providence Healthcare (Unity Health Toronto), focused on complex/high needs seniors. As a future state, we envision an integrated team consisting of existing hospital, LHIN staff, home care providers and community support services that shares the assessment, intake, eligibility, navigation, care planning, and service ordering functions for all patient populations that require support to transition from hospital to home.

A.4. Have you identified any barriers to home and community care modernization?

Identify any legislative, regulatory, policy barriers that may impede your team's vision for modernizing home and community care with regards to improving health outcomes, enhancing the patient and provider experience, and ensuring system sustainability. *This response is intended as information for the Ministry and is not evaluated.*

Max word count: 1000

A number of policy, legislation, and other barriers/enablers to the modernization of home and community care were included in section 6.4. Through the home and community care design session that the ETHP hosted with patients, caregivers and home care providers in September 2019, we identified the following additional barriers/enablers for home and community care:

- The need to leverage digital health opportunities, including virtual care and digital communications to support more effective care coordination and delivery
- The need to provide open and accessible information to patients and caregivers in a format that fits their needs (paper, USB, email)
- The need to decide where the client record information is housed; noting that family physicians and caregivers are the ones who provide care over the longest term
- Addressing home care labour issues and capacity, including personal support workers, as well as nurses and rehab therapists
- Addressing the root issues for missed visits and inconsistency in continuity of care, including labour shortages, non-guaranteed work hours, compensation, varied need for staffing at different times of the day/weekends

- Costs to and 'workload' of caregivers, insufficient financial or other supports available; lack of training/education for caregivers - Lack of access to respite, day programs – ie. non health care needs that enable wellness and caregiver support

Ontario Health Teams
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APPENDIX B: Digital Health

Experience from other jurisdictions suggests that digital health is a powerful tool for advancing integrated care, shared accountability, value-based health care, and population health management approaches.

In this section your team is asked to assess its current digital health capabilities and propose plans for building off this existing capacity to meet the minimum readiness requirements and Year 1 expectations set out by the Ontario Health Team Guidance Document. Responses provided in this section will be evaluated based on the degree to which your team seeks to integrate already existing infrastructure and improve disparities in digital capacity across the members of your team. Responses will also help the Ministry understand what supports teams may need in the area of digital health.

By completing this section, the members of your team consent that the relevant delivery organizations (i.e., Cancer Care Ontario, Health Shared Services Ontario, Ontario MD, Ontario Telemedicine Network, and/or eHealth Ontario) may support the Ministry of Health's (Ministry) validation of claims made in the Current State Assessment by sharing validation information (e.g., the number of EMR instances, including the name and version of all EMRs used by applicants) with the Ministry for that purpose.

B.1 Current State Assessment

Please complete the following table to provide a current state assessment of each team member's digital health capabilities.

Member	**Hospital Information System Instances** *Identify vendor and version and presence of clustering*	**Electronic Medical Record Instances** *Identify vendor and version*	**Access to other clinical information systems** *E.g., Other provincial systems such as CHRIS, or other systems to digitally store patient information*	**Access to provincial clinical viewers** *ClinicalConnect or ConnectingOntario*	**Do you provide online appointment booking?**	**Use of virtual care** *Indicate type of virtual care and rate of use by patients where known*	**Patient Access Channels** *Indicate whether you have a patience access channel and if it is accessible by your proposed Year 1 target population*
See supplementary Excel spreadsheet							

B.2 Digital Health Plans

Where gaps are identified through the current state assessment, the plans below should include an approach for addressing these gaps. As you articulate your plans please identify what non-financial support and services you will require from the Ministry or delivery organizations.

2.1 Virtual Care

Describe your plan for how you will build off your team's existing digital capabilities to further expand virtual offerings in Year 1. If some or all of the members of your team do not have virtual care capacity, what steps will you take to ensure that by the end of Year 1 your team offers one or more virtual services? Provide an assessment of how difficult it will be for your team to meet the following target: 2-5% of Year 1 patients who received care from your team had a virtual encounter in Year 1. Describe how you will determine whether your provision of virtual care is successful or not (e.g., measures of efficacy or efficiency).

Max word count: 1000

The ETHP understands that patients should have a choice in how to receive their care. Various virtual care options are available through the ETHP. For instance, physicians and care providers have access to eVisits and OTN offerings (telemedicine, telehomecare, teleophthalmology). Citizens in the region have access to OTN's Big White Wall, and Toronto Seniors' Helpline. The following summarizes the current use of virtual care for key programs in East Toronto:

Current virtual care volumes

Program	Servicing location	Volumes (2018/19)
Telemedicine	Michael Garron Hospital	568
Teleophthalmology	South Riverdale CHC	407
Telehomecare	Toronto Central LHIN	2,290
eVisits	Primary care practitioners	1,387
Big White Wall	Online, provided through OTN	1,596
Toronto senior's helpline	WoodGreen	780
Discharge phone call process	Unity Health	6,489

The ETHP is committed to achieving the 2-5% virtual care target in Year 1 for the priority populations. OTN estimates that currently, virtual care only accounts for 1% of all health care in Ontario. Given this, the initial plan for Year 1 is to double

the current volumes. The target is a proxy while the team works to have a better understanding of the baseline and denominators. The current virtual care program serves as a strong foundation for our Year 1 goal. This includes eVisits for primary care and teleophthamology screening program run by South Riverdale CHC. The following represents a set of activities planned for Year 1, with a focus on scaling existing solutions.

1. Expand eVisit program to up to 25 additional primary care physicians, representing an estimated 1,300 additional total evisits. The eVisits pilot was successfully launched in Toronto Central LHIN in 2018/19, with a total of 48 physicians and 2,552+ eVisits took place across the region. In FY19/20, there is a commitment to regional expansion of this program with a priority focus on reaching those patients in catchments for advancing OHTs, including East Toronto. Through the developing family practice network, the goal of this initiative is to target eVisit adoption by an additional 25 physicians.

2. Develop targeted virtual strategies for seniors with chronic disease and caregiver population. This includes expanding on early successes of the Home 2Day program at Michael Garron Hospital, which targets patients with COPD and CHF conditions. In Year 1, we can expand this approach to patients with heart failure (2,734 people) and patients hospitalized for pneumonia (12,055 people) to expand our reach. This program was initially launched in December 2018, and patients received enhanced home care services from WoodGreen and VHA Home HealthCare. This included 24/7 care navigation, virtual connection to MGH specialists and connections to support caregivers at home. In 2018/19, 177 patients from the East Toronto region enrolled for this service, and 2,290 health-coaching sessions (between a clinician and patient, where both parties review results and goal settings) took place over the phone. There is significant opportunity to increase enrollment for ETHP patients, and the initial goal is to identify opportunities to leverage this program further for the OHT.

In addition, Providence has Telemedicine Impact Plus (TIP), which provides rapid access to a virtual team of professionals to enable proactive health and social care for patients with complex conditions and their family caregivers and is a billable services that provides a coordinated care plan. Forty-five patients were supported in 2018/19.

3. Michael Garron Hospital is developing a process plan for integrating virtual visits into traditional care pathways and home specialist visits. In addition to the hospital to home care program (Home 2 day) described above, there are other areas that MGH is looking to better integrate virtual visit in order to improve patient care:

a) Children and youth mental health – There is an initiative underway, looking into how best to engage patients who are too anxious to leave their homes. The team has currently identified several barriers to addressing this population; e.g.,

bandwidth, access to WiFi, difficulties with scheduling and registration. The goal is to find a unified way to schedule patients into the Cerner system, and will work with OTN and their third-party vendors to streamline the process.

b) Enhanced connection to specialists – Expand the use of eConsult, as there have been expressed interest from dermatologists and other sub-specialties. This would increase primary care access to specialists in the East.

c) Post-discharge follow-ups, health literacy, and self-care management – Opportunities are being assessed to use virtual care to improve overall transition of patients into community.

4. Leverage existing app-based technology to facilitate access to 24/7 support around mental health and addictions issues and youth. One example is the virtual counselling services that are under development for children and youth through the network of six What's Up Walk In (WUWI) clinics that provide single-session solution-focused counselling. Newly acquired video-conferencing technology will be deployed to pilot this new approach to delivering brief therapy. The aim is to enable access to single-session counselling through devices operated by an individual (computer, mobile phone, etc.) that allow connection to the WUWI clinics.

The ETHP is proposing the following measures to determine the success of virtual care, including:

- Percentage of in-person encounters that could have been completed virtually, instead
- Patient reported experience measures related to virtual care visits
- Overall growth of virtual care interactions, stratified by type and population
- Provider satisfaction measurement as it relates to virtual care offerings and alignment with clinical workflow

Through private sector engagement at the "vendor day", additional opportunities for test of change were identified that would align with our priority populations. The next step is to prioritize initiatives with anticipated impact. One key point raised was health literacy, and the opportunity to leverage consumer digital tools to promote better health and educate patients in self-care. Potential partnerships on this topic are being explored.

2.2 Digital Access to Health Information

Describe your plan for how you will build off your team's existing digital capabilities to provide patients with at least some digital access to their health information. Provide an assessment of how difficult it will be for your team to meet the following target: 10-15% of Year 1 patients who received care from your team digitally accessed their health information in Year 1.

Max word count: 1000

The East Toronto Health Partners believe that digital health is critical to a patient-centered integrated care. This includes the need to ensure patients are empowered with access to personal health information, their providers, and other necessary tools that will support them in their care. At the core of meeting this need, it is contemplated that the ETHP will establish a "consumer gateway". By using this approach, we will balance the use of existing solutions, while embracing the fact that consumers will ultimately have choice in how they receive information. The critical component to this, is the ability to leverage a common identity management solution for patients. Specifically, this proposed work and alignment is outlined below:

- Exploring solutions to maintaining and managing patient identify and consent. The East is one of the partner organizations that collaborated in a submission to the IAA call for proposals. Furthermore, we continue to monitor activity in this space nationally given the work to date of Canada Health Infoway. There is a commitment from the executive leadership to pursue opportunities to jointly leveraging existing solutions that can better facilitate access and management of patient identify, enabling a gateway to digital tools and information within the OHT. Like banking and the Canada Revenue Agency websites, the ETHP believes that a single identity management solution is critical to securely and seamlessly connecting patients into the digital ecosystem.

- The development of an ETHP "Gateway" as a front door for citizens to get access to a suite of digital tools is being planned for. The goal is to enable a single point of entry to solutions such as MyChart, PODS, virtual care tools, and health/digital health literacy. This gateway will also facilitate collection of PREMs and PROMs, which will enable quality improvement and continuous learning.

If successful, this infrastructure will be in place by end of year 1. In the meantime, the following initiatives will enable ETHP to meet early targets for patient access to their information digitally:

1) Increase adoption of MyChart at MGH. MyChart has been implemented at MGH since July 2016, and there are approximately 3,741 users are registered within the hospital. With average annual unique patient volumes of approximately 116,000, only 3% of MGH patients currently access their digital health record. Promoting use and adoption of MyChart by MGH patients will be a priority in Year 1. With an estimated Year 1 priority population of 69,000, the goal will be to identify and target a minimum 6,900 of those priority population patients that visit MGH and enable them to have registered access to MyChart. Currently, MGH is collaborating with Sunnybrook in order to streamline the onboarding process.

2) Implementation of MyChart for other anchor partners. Two anchor partners, VHA and WoodGreen, are in the initial planning stages of implementing MyChart at their respective organizations, this will not happen for Year 1.

3) Adoption of MyChart by patients through CHRIS / Care Coordinators. By February 2020, it is expected that home care clients can be registered to MyChart via home care staff and through connection to CHRIS. The enrollment process begins with care coordinators recording the patient's consent to enroll into MyChart in CHRIS. The patient will complete the enrollment process online via a link sent in an email.

4) Participation of ETHP patients in Patient Oriented Portal pilot project. The ETHP recognizes that patients ought to be able to access their health information digitally, and institutional portals may not always be their top choice. As such, there is a patient oriented pilot project underway. This project explores three non-institutional portals that patients can use to access their health information. Approximately 50 participants from the East Toronto region will be enrolled into this pilot project.

The ETHP is committed to a citizen digital priority, and empowering patients in their care is in alignment with the regional Consumer Digital Strategy, which focuses on three main areas: access to information, connecting and navigating the health system and improving digital health literacy. ETHP has the ability to leverage content/tools/resources generated by the citizens' panel to help inform, educate and support patients in their digital health journey. Examples of content include:

- FAQ document about patients' digital rights to health information and how to access it
- Universal life flow report, a narrative and anchoring framework for how patients view their journey with the health system through the course of their lives with the end goal of identifying systemic gaps and pressures that can be addressed by digital solutions (including recommendations for equal access to real-time health information)

2.3 Digitally Enabled Information Sharing

Describe your plan for ensuring that patient information is shared securely and digitally across the providers in your team for the purposes of integrated care delivery, planning (e.g., pooling information to understand population health needs and cost drivers, population segmentation, integrated care pathway design).

Max word count: 1000

The ETHP digital committee listed seven principles upon which it would use to guide the team to digital maturity. One of which is the notion that the liberation of data is the blueprint for building a successful OHT. Common elements such as data sharing, privacy and security policies, and identity management must not be barriers to implementing tools that would promote the efficient delivery of health care.

One of the core digital principles for the ETHP is that there should be seamless exchange of information and communication across health partners. This is the most fundamental need of an integrated care system, and ETHP is committed to ensuring a clear approach is in place to liberate the data for better care, improved experience, and more sophisticated planning through a learning health system model. In the short term, the goal is to continue to utilize existing tools and assets to facilitate information sharing, e.g. Health Report Manager (HRM). In the longer term, a strategic vision needs to be executed on which will ensure there is full data integration of information front a patient perspective, and that this information can be consumed freely within the construct of the integrated care system.

Building on current state:
As a potential OHT candidate, the East partners are digitally well connected. Michael Garron Hospital has been contributing to ConnectingOntario since mid-2018. Most partners are able to view patient information through ConnectingOntario, with plans for VHA to onboard in the near future. All partners have access to ONEMail, and MGH is a provincial leader in sharing hospital information to primary care and community through HRM and eNotification. In fact, MGH is one of the few hospitals sharing the full set of HRM reports. Within the community setting, eCCP is enabled across most of the ETHP anchor partners, with the goal to complete implementation to remaining partners this fiscal (MGH and VHA).

1) Set a strategic direction for data aggregation. For year 1, the goal is to develop a shared architecture for how data across all organizations will be collected, stored, and shared. The intent is to leverage the existing Provincial EHR as the technology backbone that will enable this. A working group has been established to deliver on this priority.
2) Create a common privacy, security, cyber-security and data governance policy. In partnership with other OHTs, and with provincial support, the goal for year 1 is to have an agreed-upon framework for ensuring there is consistency across the integrated team on how we safeguard and govern our information.
3) Enable secure messaging between providers (and eventually, patients). While sharing clinical information is critical to patient outcomes, the ETHP understands that facilitating communication between providers is equally important. A current-state assessment revealed that anchor partners had various forms of internal instant messaging (Hypercare, Microsoft Teams, Skype, etc). As such, the ETHP will initiate a secure instant messaging pilot project in October 2019 to

enable font line staff across various organizations to have access to a common platform that is PHIPA compliant. Upon a successful pilot, a common solution will be rolled out across the ETHP anchor partners by the end of Year 1.

4) Connect primary care to provincial assets. The ETHP will continue to ensure the digital flow of information amongst providers by continuing the roll-out of the ONEID bundle in partnership with Ontario MD (OMD). Currently 40+ physicians in the EasT-FPN have access to Connecting Ontario. The bundle will enable our physicians to have secure email, access to eConsult, ConnectingOntario, and the Health Services Directory, which provides an up-to-date listing of specialists and community services available to help navigate the needs of their patients. The EasT-FPN has family physician members who are recognized provincial leaders and early adopters in digital care, and who will readily participate in innovation and spread. A “digital concierge” project is currently being considered for primary care, which aims to provide direct support to family physicians in order to improve the use of digital tools to optimize their clinical workflow.

5) Optimize home and community care coordination. Home and community care coordination plays a significant role in healthcare and is critical in solving the issue of seniors with chronic disease management and their caregivers. The Year 1 work plan includes targets like; provide full HPG access to all East Toronto providers, prioritize information-sharing needs in the community, and implement ConnectingOntario at VHA (and eventually, all service provider organizations). It is envisioned that home and community care organizations will also have access to eNotifications in the future. Toronto Central LHIN developed a unique in-house tool, Case Navigator (C-NAV), which uses algorithms to determine high-risk clients. These clients are brought to the care coordinator’s attention for immediate action. By February 2020, it is expected that care coordinators will be able to enroll patients into MyChart using CHRIS, thereby enabling patients to take more control over their care information. The ETHP will work with HSSO and other OHTs to determine additional features that can be CHRIS can further optimize home and community care.

6) Organization-specific initiatives to improve information sharing locally. Several East Toronto anchor partners are working on internal initiatives to improve information sharing amongst its walls. WoodGreen is planning to implement a new database to manage client’s health information (expected to be operationalized by early 2020). In addition, VHA’s Pixalere system allows clinicians within the organization to share information.

2.4 Digitally Enabled Quality Improvement

Describe how the members of your team currently use digital health tools and information to drive quality and performance improvement. How will your team build off this experience and capability so that it exists at the team-level?

Max word count: 500

Quality improvement is synonymous with the philosophy of continuous learning. The third idea within the digital strategy framework is to enable an intelligent learning system through data and technology. There exists tremendous potential to leverage shared data among the partners for CQI, clinical decision support, and increasingly sophisticated analytics models that will empower the care teams with important insights about the population function of the system as a whole.

The various projects that are planned for year 1 have quality improvement initiatives built into the project plan. The following highlights the key initiatives and alignment with QI:

1) Develop a data and analytics strategy. In addition to the core infrastructure for enabling access to data for QI, performance and planning, a broader approach needs to be developed that can concretely translate these plans into tangible priorities. For instance, Michael Garron Hospital has already implemented an ED forecasting model that can predict ED volumes accurately up to 6 months in advance. This leveraged the model developed by Unity Health. There are a number of other planning questions that need to be asked and answered by the OHT to improve delivery of care and patient outcomes. A methodical approach to design this is required, including front-line input, determining the modeling methods, and the ability to deliver these insights in a meaningful way to the users. The strategy will encompass all of these considerations, and leverage existing intelligence tools (BI infrastructure, Power BI or other visualization technologies) to deliver on this.
2) Implementation of a population health management solution. As highlighted in section 4.3.1, one of the key components of a future OHT digital ecosystem is a population health solution that will facilitate identification of risks, match patients with the appropriate care programs, and inform clinical and planning decisions. This tool will be central to the data and analytics strategy noted above.
3) Optimizing home and community care coordination. Recently, the Toronto Central LHIN developed an in-house case navigation tool (CNAV) that helps community providers organize their caseload, based on priority needs clients. This dashboard uses analytics and business intelligence tools to determine which patients require attention and brings the case to the top of the care coordinator's list. Rolling out this tool to home and community providers in the East partnership is on the Year 1 work plan. They key to this solution is the implementation of the risk identification model using CIHI analysis on flagging high risk seniors that are likely to need long term care.

2.5 Other digital health plans

Please describe any additional information on digital health plans that are not captured in the previous sections.

Max word count: 500

There are three key ideas that encapsulates the digital vision of the East Toronto Health Partners:

Idea #1: Achieve Digital Connectivity. This idea encompasses the body of work related to exchange of information and open communication that is fundamental to an OHT.

Idea #2: Digital-First Customer Service. Using digital health, we want to shift the thinking from patient to citizen and client to customer. In doing so, the ETHP will prioritize solutions that support health equity, positive experiences, and flexible (virtual) care solutions.

Idea #3. Foster an Intelligent Learning System. A structured, digital footprint that can facilitate the learning and evidence-based approach to maturing as an integrated health system. This includes advancing predictive capabilities based on use of data, establishing an operational command center, and enabling innovation.

In alignment with these key ideas, the ETHP is working on other digital initiatives that have not been previously highlighted, including:

1. (Digital) Solutions for local priority populations.

a. Implementation of a navigation and access solution, targeting the youth mental health priority population for Year 1. The goal is to leverage an existing regional or provincial solution to help connect the youth population with mental health services. It is expected that the navigation and access tool recommended for this population will be scalable for the other priority populations.

2. Creating a common privacy and security framework. As noted in section 4.3.1, the ETHP understands that solving issues related to privacy and security may require an approach that extends beyond the OHT. Initial steps to achieve this include referencing the Digital Playbook and policy guidelines, leveraging existing supports that include the Policy Themes report published by the TC LHIN Digital Delivery Centre of Excellence (CoE), and establishing a privacy working group with representatives from each of the anchor organizations to drive this work forward.

Furthermore, respective anchor partners continue to pursue important organizational initiatives, with the intent to align to the OHT digital plan and support the future goals of the OHT. Highlights of these activities include:

• Implementation of Procura at WoodGreen to improve core client information management capabilities; • VHA was Ontario's first LHIN-contracted home care provider to fully digitize patient charts within its nursing practice through the implementation of an EMR and continues to deploy this throughout their organization - plans include go-live with their Physiotherapy practice in November 2019; • As Michael Garron Hospital completes its capital redevelopment, there continues to be a focus on implementation of digital technology in the new environment to further support integrated care as an OHT

B.3 Who is the single point of contact for digital health on your team?

Please identify a single point of contact who will be the responsible for leading the implementation of digital health activities for your team.

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