

May 15, 2019

Hon. Christine Elliott  
Ontario Minister of Health and Long-Term Care  
College Park 5th Flr,  
777 Bay St, Toronto  
ON M7A 2J3

**RE: Ontario Health Team Submission from the East Toronto Health Partners**

Dear Minister Elliott,

Thank you for visiting the East Toronto Health Partners (ETHP) in March, to learn about the integrated care we deliver for the community of East Toronto. In follow-up, we are pleased to submit an application from the ETHP to become an Ontario Health Team. As the anchor organizations for a 'Network of Networks', the ETHP represent the full continuum of care, and bring a commitment to expanding our partnership to serve everyone living in our community, delivering integrated service offerings to patients – where, when and how they want to receive care in East Toronto. We are:

- Patients, Families and Caregivers
- Michael Garron Hospital (Toronto East Health Network)
- Providence Healthcare (Unity Health Toronto)
- South Riverdale Community Health Centre
- VHA Home HealthCare
- WoodGreen Community Services
- Toronto Central LHIN Home and Community Care

In addition, we have a commitment by local Primary Care Physician Leaders to developing an East Toronto Primary Care Network.

Collectively, our partners serve approximately 300,000 residents, and are the predominant health care providers to our community. Our boundaries span from the Don River to the West, to Warden in the East, and from South of Eglinton Ave to Lake Ontario; and extends to include communities such as Thorncliffe Park and Flemingdon Park. There are 21 distinct neighbourhoods in East Toronto, although we serve Ontarians across the Greater Toronto Area and North of the city.

We feel the predominance and full continuum of care that our partners represent, the defined geography and catchment of East Toronto, and the expansive service offerings we plan for Year 1 make the East Toronto Health Partners an ideal early Ontario Health Team for the Province to consider.

## Our Vision for Integrated Care in East Toronto, Built on a Momentum of Trust

As long-time partners, we established a shared vision that an East Toronto Ontario Health Team will advance the Quadruple Aim through 'A System without Discharges': A seamless continuum of care that is population health focused, with programs tailored to local communities.

The ETHP delivers a comprehensive basket of health and social services, tailored to meet changing local needs. We are building on the momentum of established trust and long-standing collaboration of community-focused partners with more than 40 years collectively serving East Toronto, and over 20 years delivering [Solutions](#) to East Toronto together. In late 2017, the CEOs of the ETHP came together to discuss an integrated care network, and since invested over 1.5 years on direct service integration, utilizing a joint venture approach with shared governance and resources.

### East Toronto Health Partners Integrated Care Vision: A System without Discharges



Building on the early work of the ETHP, we developed this vision of 'A System without Discharges' not only on our own, but together with over 70 health system stakeholders and patient partners in a series of workshops to define our future as an Ontario Health Team.

Our goal is to create an integrated health system for the 300,000 people who live in East Toronto. Our focus in Year 1 will be to integrate care for three populations:

- Seniors and caregivers, with a focus on chronic disease
- People living with mental health challenges and addictions
- Priority Neighbourhoods to meet the local needs of diverse communities

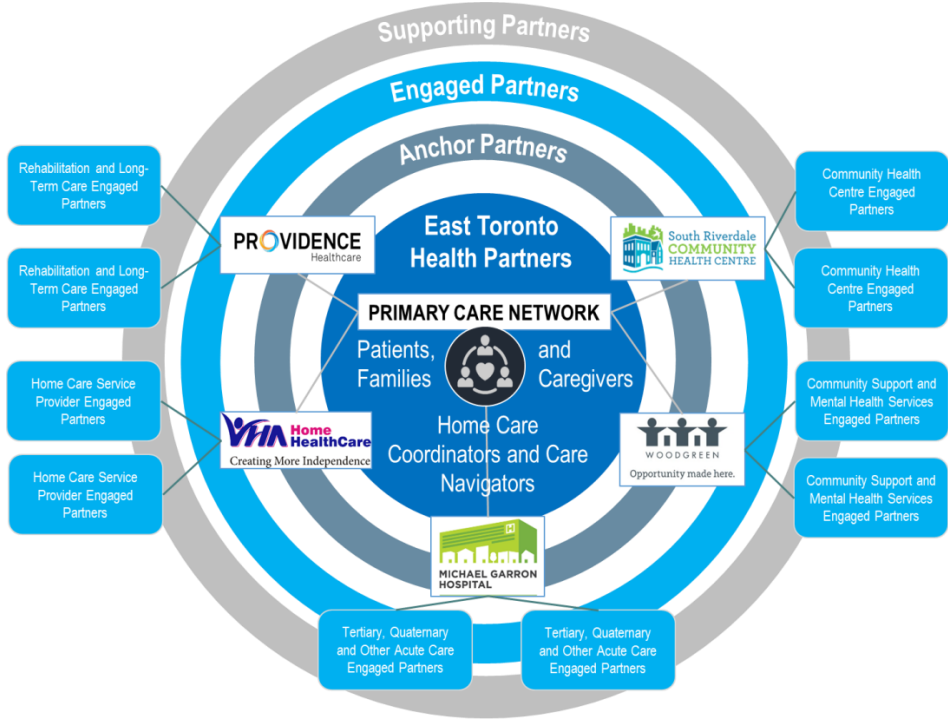
Across these Year 1 populations, ETHP will serve approximately 150,000 people, 50% of East Toronto. As we progress, we will expand our focus to perinatal and pediatric care, including existing integrated midwifery care models, and to integrated palliative care. Combined with existing primary care, emergency care and home and community care services across ETHP, this will expand the ETHP and our service to the full population of 300,000 residents in East Toronto, at maturity.

To best serve these priority populations in Year 1, ETHP will build on existing work to understand key cost drivers, seek efficiencies for reinvestment, and optimize resource sharing to best serve our communities.

**Our Partnership Model**

The ETHP plan for an integrated network model across providers serving the community of East Toronto, based on three levels of partners that support patient and families: Anchor Partners, including the core members of this Self-Assessment; Engaged Partners, who are actively involved in the planning, funding and delivery of specific initiatives; and Supporting Partners, who remain informed and involved periodically, but are not active in ongoing planning or delivery. Important to our partnership model is the notion of ‘fluidity’ – where the ETHP is open to movement of partners across the different tiers, as we work to expand and strengthen the partnership.

**East Toronto Health Partners: Integrated Care Through a Network of Networks**



Central to this “Network of Networks”, a critical component of the ETHP is developing the **East Toronto Primary Care Network**. A group of primary care physician leaders and champions across multiple primary care models (CHC, FHT, FHO, solo practice) committed to “*Come together as a primary care network that supports shared governance and leadership in an OHT, such that key elements that are needed to further integrated care in East Toronto are actualized through primary care.*” This approach places primary care and their support to the community of East Toronto at the heart of our ‘Network of Networks’. Supported by our vision to embed the home care coordination functions in the ETHP, this Primary Care Network becomes a central point of coordination, care navigation and engagement of patients, families and their caregivers living in East Toronto.

## **Our Momentum**

The model above describes how the ETHP came together, building on the momentum established by our anchor partners. We know the key success factor to establishing high performing networks is a high level of trust. While most critical, trust is the hardest component to measure and demonstrate. Mutual trust is a core strength and value of the ETHP. Our trust with one another is demonstrated by:

1. Solidifying our commitment as partners well before the launch of the OHT process, with a shared vision and guiding principles established in Winter 2017, endorsed by our respective Board Chairs. In 2018, we signed a Letter of Intent to move toward integrated care (included in the Appendix).
2. Committing to building an integrated East Toronto health system, above our own organizational interests.
3. Our history of collaborative projects that demonstrate results, such as delivering an integrated funding and resourcing response to winter surge, and moving forward on integrated leadership for mental health and addictions.
4. Sharing information, performance measures and resources, including joint quality improvement initiatives and funded resources
5. Consistent communication: The CEOs meet weekly, as do our senior team members, communications departments and digital health leaders; and our larger committee with additional stakeholders meets monthly to help design care pathways.
6. A commitment of over 30 engaged partners to be part of the ETHP, as we advance integrated care in East Toronto.

Supporting our shared vision and history of collaboration, the ETHP have a strong existing digital infrastructure at each anchor partner, many common systems across our primary care partners, and an interest to better integrate digital approaches to improve care delivery.

In addition to our self-assessment, we include the following referenced companion material throughout that is provided as an appendix to this submission:

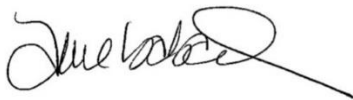
- Our Vision, Goals and Principles for the East Toronto Health Partners' Ontario Health Team
- A Listing of Over 30 Engaged Partners, Confirmed in the ETHP
- Population Health Demographics for East Toronto
- Example of Early ETHP Successes
- The ETHP Digital Action Plan
- Our Implementation Priorities and Future State Care Models for Year 1 Priority Populations
- An Excerpt from the 'Letter of Intent' to Integrated Care, Signed by Anchor Partners in Fall 2018

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The Province's shift to Ontario Health Teams accelerates the momentum of the East Toronto Health Partners, and enables us to build on these foundational 'proof points' of trust and integration. We identify several enablers for change in our self-assessment for the Ministry's consideration, and are confident that, with your support, East Toronto is ready to be a leader in this movement toward integrated care.

We are excited to submit our self-assessment and to request your consideration as an early leader in establishing one of the province's first Ontario Health Teams.

Sincerely,



Anne Babcock

President and CEO, WoodGreen Community Services

On behalf of the East Toronto Health Partners

c. Dr. Rueben Devlin, Special Advisor and Chair of the Premier's Council on Improving  
Healthcare and Ending Hallway Medicine

Helen Angus, Deputy Minister, Ministry of Health and Long-Term Care

East Toronto Health Partners

# Ontario Health Team Self-Assessment Form

## Overview of the Process to Become an Ontario Health Team:

- The Self-Assessment is the first of a multi-stage Readiness Assessment process to become an Ontario Health Team Candidate.
  - 1. Self-Assessment (open call):** Interested groups of providers and organizations are invited to submit a Self-Assessment. Submissions will be evaluated to determine the likelihood that groups would be able to submit a comprehensive Full Application and adhere to the readiness criteria for Ontario Health Team Candidates set out in the *Ontario Health Teams: Guidance Document for Health Care Providers and Organizations*.
  - 2. Full Application (invitational):** Based on Self-Assessment evaluations, selected groups will be invited to complete a Full Application.
  - 3. In-Person Visits (invitational):** Based on Full Application scoring, a short list of groups will be selected for in-person visits in order to identify those most ready to begin implementation of the Ontario Health Team model.
- This process will be run on a regular basis, with further application dates to be communicated at a later date. All groups of providers and organizations who participate in the assessment process will receive access to supports that will help improve readiness for eventual implementation of the Ontario Health Team model.

## Guidance for Completing the Self-Assessment:

- Please refer to *Ontario Health Teams: Guidance for Health Care Providers and Organizations* document to complete this form.
- This form should be endorsed and signed-off by leadership from all participating providers/organizations. While Board approval is not required due to the short timeframes of the Self-Assessment, participants are expected to confirm the highest level of commitment possible.
- Answers to relevant questions should be clear and concise. Supporting documentation may be supplied.
- Submit the Self-Assessment form to [OntarioHealthTeams@ontario.ca](mailto:OntarioHealthTeams@ontario.ca).
- Where appropriate, the Ministry of Health and Long-Term Care (the Ministry) may suggest that groups that submit separate Self-Assessments collaborate to re-submit a joint assessment.
- Please contact [OntarioHealthTeams@ontario.ca](mailto:OntarioHealthTeams@ontario.ca) for any inquiries regarding this Self-Assessment form.

# Ontario Health Team Self-Assessment Form

**Please note:**

- 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). 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.
- All applications submitted to the Ministry are subject to the public access provisions of the *Freedom of Information and Protection of Privacy Act* (FIPPA). If you believe that any of the information you submit in connection with your application reveals any trade secret or scientific, technical, commercial, financial or labour relations information belonging to you, and you wish that this information be treated confidentially (subject to applicable law) by the Ministry, you must clearly mark this information “confidential” and indicate why the information is confidential in accordance with s. 17 of FIPPA.
- 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.
- In addition, the Ministry may disclose the names of the successful applicants and any other material that is subject to the public access provisions of FIPPA.

# Ontario Health Team Self-Assessment Form

## Part I: General Information and Commitments

### Who are the members of your team?

*Please identify the list of health care providers and/or organizations that would partner to form the proposed Ontario Health Team. Please explain why this group of providers and organizations has chosen to partner together.*

#### **PART I – Members of the Team**

Representing the full continuum of care, the East Toronto Health Partners (ETHP) are a 'Network of Networks', committed to serving all community members wishing to receive care in East Toronto. We are:

- Patients, Families and Caregivers
- Michael Garron Hospital (Toronto East Health Network)
- Providence Healthcare (Unity Health Toronto)
- South Riverdale Community Health Centre
- VHA Home HealthCare (VHA)
- WoodGreen Community Services (WoodGreen)
- Toronto Central LHIN Home and Community Care

In addition, we have a commitment by local Primary Care Physician Leaders to Create an East Toronto Primary Care Network.

**Our Vision** – 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.

**Our Catchment Area** - Collectively, we serve approximately 300,000 residents in East Toronto across 21 distinct neighbourhoods. We are one of the few Toronto areas served predominantly by the proposed Ontario Health Team. ETHP spans from the Don River to the west, to Warden in the East, and from south of Eglinton Ave to Lake Ontario; extending to also include Thorncliffe Park and Flemingdon Park.

**Our Partnership Model** - ETHP delivers a comprehensive basket of health and social services, tailored to meet changing local needs. Relationships build at the 'speed of trust', and ETHP has a multi-decade track record of delivering 'made in East Toronto' solutions together. Building on this legacy of trust, for the past 2 years, the ETHP focused its collaborative efforts on direct service integration. Our partnership envisions a 'Network of Networks' having a joint venture with shared governance and resources. Building on the momentum of the past two years, the ETHP will establish a network of providers serving East Toronto, based on three levels of partnership: **Anchor Partners**, including the core members of ETHP; **Engaged Partners**, actively involved in the planning, funding and delivery of specific initiatives; and **Supporting Partners**, who remain informed and involved, but not active in planning or delivery.

Central to the ETHP is developing the **East Toronto Primary Care Network**. A group of primary care physician leaders and champions commit to: *"Come together as a primary care network that supports shared governance and leadership in an OHT, such that key elements that are needed to further integrated care in East Toronto are actualized through primary care."* This approach places primary care and their support to the community of East Toronto at the heart of our 'Network of Networks'.

The Province's health care redesign accelerates the momentum of trust and collaboration that is foundational to our partnership. ETHP is confident we are ready to be one of Ontario's first Health Teams.

### Commitment to collaborate with others

*Please confirm that you are willing to work and engage with other interested groups in your geographic area to collaborate towards becoming an Ontario Health Team, if recommended by the Ministry.*

### Commitment to the Ontario Health Team vision

*Please confirm that all proposed partners have read the Ontario Health Teams: Guidance for Health Care Providers and Organizations in full and are committed to working towards implementation of the Ontario Health Team Model.*



# Ontario Health Team Self-Assessment Form

## Part II: Self-Assessment Scoring

### Model Component 1: Patient Care and Experience

**At maturity**, Ontario Health Teams will offer patients, families and caregivers the highest quality care and best experience possible. Patients will be able to access care when and where they need it and will have digital choices for care. Patients will experience seamless care from providers who work together as a team. They can access their health information digitally, and their providers ensure they know what to expect in each step of their care journeys. Patients can access coordination and system navigation services whenever they need to.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• You can identify opportunities and targets and can propose a plan for improving access, transitions and coordination of care, and key measures of integration	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• You are able to propose a plan for enhancing patient self-management and/or health literacy for at least a specifically defined segment of your Year 1 population	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• You have the ability and existing capacity to coordinate care across multiple providers/settings for Year 1 patients and you will be able to quantify this capacity (e.g., FTE count)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• Your team is committed to			
➤ Measuring and reporting patient experience according to standardized metrics and improving care based on findings	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
➤ Putting in place 24/7 coordination of care and system navigation services, available to Year 1 patients who require or want these services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
➤ Offering one or more virtual care services to patients	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• You are able to propose a plan to provide patients with some digital access to their health information	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Self-Assessment Scale for Patient Care and Experience**

*Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.*

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Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

# Ontario Health Team Self-Assessment Form

## Rationale (250 words maximum)

*Please provide a rationale for your self-assessment response*

Our partnership begins in the community, with individuals, families and their primary care teams, to ensure the strengthening of a connected foundation for everyone in East Toronto. Building on a number of ETHP joint initiatives already underway, we will enhance patient care experiences by focusing on three key patient populations in Year 1:

- 1. Seniors and caregivers:** East Toronto has a significant population of seniors (14%) and heavy burden of chronic illnesses including Chronic Obstructive Pulmonary Disease (COPD) and Congestive heart failure (CHF). Their care needs result in high levels of hospital admissions, and long lengths of stay, contributing to hallway medicine pressures. In December 2018, we launched “Home 2 Day” to transition COPD inpatients from MGH home with enhanced home care service from WoodGreen and VHA. This program includes 24/7 care navigation, virtual connection to MGH specialists, shared quality metrics, and connections to caregivers at home. In Year 1, we will expand this program to include CHF, pneumonia and post-surgery transitions home. Across the Home 2 Day program, we support improved self-care management, to increase capacity at home. We will also address caregiver distress, social isolation, and improve access to advanced care planning and palliative care.
- 2. People living with mental health challenges and addictions,** including more than 21% of people in East Toronto, with some neighbourhoods like Taylor Massey have 3X higher Emergency Department (ED) use for youth mental health than the Toronto Central average. In Year 1, we will focus on:
  - **Youth Wellness Centres** to link hospital, community and primary care providers, supported by 24/7 youth mental health and addictions navigators
  - **Coordinated Harm Reduction,** including Withdrawal Management, Rapid Access to Addictions Medicine, Mobile Crisis Intervention Teams and Crisis Services
  - **Joint East Toronto Director of Mental Health and Addictions,** to advance service integration across the ETHP
- 3. Priority Neighbourhoods to meet the local needs of diverse communities:** East Toronto includes five “Neighbourhood Improvement Areas” as defined by the City of Toronto. Health Access Thorncliffe Park, a formal collaboration between Flemingdon Health Centre and The Neighbourhood Organization, provides primary care and wraparound services to the Thorncliffe Park community, and is leading the development of a new multi-service neighbourhood centre scheduled to open in 2020. To address high usage of the hospital emergency department, and to better link inter-professional teams to local family physicians, we invested in Neighbourhood Care Teams. In Year 1, we will complete the integration of care for these two Neighbourhood Care Teams, and at maturity, we will expand access to neighbourhood-based inter-professional teams through our evolving Primary Care Network and community service partners.

Supporting these populations, and all of our community, Home and Community Care aligned thirty-five (35) Care Coordinators to support health care system navigation in East Toronto. Embedded in neighbourhoods, Care Coordinators 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). Care Coordinators are an inter-professional team of Regulated Health Professionals with skills in assessment, care planning, and system level resources, who form an important part of our ability and existing capacity to coordinate care across multiple providers/settings for Year 1 patients.

# Ontario Health Team Self-Assessment Form

## Model Component 2: *Patient Partnership & Community Engagement*

**At maturity**, Ontario Health Teams will uphold the principles of patient partnership, community engagement, and system co-design. They will meaningfully engage and partner with - and be driven by the needs of - patients, families, caregivers, and the communities they serve.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Each partner in the team can demonstrate a track record of meaningful patient, family, and caregiver engagement and partnership activities <sup>1</sup>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• You are able to propose a plan for how you would include patients, families, and/or caregivers in the governance structure(s) for your team and put in place patient leadership	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• Your team is committed to			
➤ The Ontario Patient Declaration of Values	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
➤ Developing a patient engagement framework for the team	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
➤ Developing a team-wide, transparent, and accessible patient relations process for addressing patient feedback and complaints and a mechanism for using this feedback for continuous quality improvement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• If you intend to involve patients, families, and caregivers in the design and planning of a subsequent Full Application (if invited), you would be able to do so meaningfully and would be able to demonstrate evidence to this effect	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• If you intend to engage your community in the design and planning of a subsequent Full Application (if invited), you would be able to do so meaningfully and would be able to demonstrate evidence to this effect	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• Your team adheres to the requirements of the <i>French Language Services Act</i> , as applicable, in serving Ontario's French language communities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A

<sup>1</sup> Examples include presence of a Patient and Family Advisory Council within each partner organization, reporting to senior leadership (CEO or Board) to provide direction on strategic issues; inclusion of patient partners on key committees, including hiring committees; patient experience is a key focus for each partner organization with defined targets for meeting/exceeding patient experience metrics. This list is provided for example only and is not exhaustive.

# Ontario Health Team Self-Assessment Form

- If your team is proposing to be responsible for geography that includes one or more First Nation<sup>2</sup> communities you will be able to demonstrate support or permission of those communities   N/A

## Self-Assessment Scale for Patient Partnership & Community Engagement

*Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.*

Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

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<sup>2</sup> For a map of First Nations communities and reserves, please refer to the following link:  
<https://www.ontario.ca/page/ontario-first-nations-maps>

# Ontario Health Team Self-Assessment Form

## **Rationale** (250 words maximum)

*Please provide a rationale for your self-assessment response.*

Since our inception, ETHP leaders 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. We also engaged with the Year 1 population groups to design the future state of health care in East Toronto, and commit to continuing to involve patients/families in co-design, monitoring and program enhancements.

Among the ETHP, we have a long history of successfully engaging patients with significant barriers to participation including urban indigenous partners, individuals with active substance use, community members living with chronic disease and diverse populations with cultural and language barriers. These community members regularly contribute to program co-design, evaluation, research and service delivery, aligned with the Ontario Patient Declaration of Values active engagement approach.

### **A more comprehensive engagement plan will:**

1. Secure ongoing membership within the future governance model to ensure patient involvement in priority setting and decision making
2. Link our existing client/patient and caregiver committees to conduct joint strategic planning, model of care development and refinement, creating a joint ETHP Patient and Family Advisory Council (PFAC)
3. Identify and resolve gaps in representation to ensure a health equity approach, work with people with lived experience, and build trusted relationships with our local communities
4. Engage 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

Further, although East Toronto does not have any First Nations reserves, it does have a large Aboriginal population; many of the ETHP have Aboriginal programs across our partners, delivered in partnership with Aboriginal leaders and Elders. Moving forward, we will 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.

# Ontario Health Team Self-Assessment Form

## Model Component 3: Defined Patient Population

**At maturity,** Ontario Health Teams will be responsible for meeting all health care needs of a population within a geographic area that is defined based on local factors and how patients typically access care.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Your team is able to identify the population it proposes to be accountable for at maturity	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• Your team is able to identify the target population it proposes to focus on in Year 1	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• Your team is able to define a geographic catchment that is based on existing patient access patterns	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• You know how you will track (e.g., register/roster/enrol) the patients who receive services from your team in Year 1	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• Of your Year 1 target population, you are confident that you will be able to deliver integrated care to a high proportion of this population and can set an achievable service delivery volume target accordingly	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A

### Self-Assessment Scale for Defined Patient Population

*Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.*



Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

# Ontario Health Team Self-Assessment Form

## **Rationale (300 words maximum)**

*Please provide a rationale for your self-assessment response.*

*In addition, please include in your response:*

- *Who you would be accountable for at Maturity – describe the proposed population and geographic service area that your team would be responsible for at Maturity. Include any known data or estimates regarding the characteristics of this population, such as size and demographics, 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.*
- *Who you would focus on in Year 1 – describe the proposed target population and geographic service area that your team would focus on in Year 1. Include any known data or estimates regarding the characteristics of this population and explain why you have elected to focus on this population first.*
- *Note: Based on patient access patterns and the end goal of achieving full provincial coverage with minimal overlap and transitions between Ontario Health Teams, the Ministry will work with Teams to finalize their Year 1 target populations and populations at maturity.*

ETHP will create an integrated health system for the 300,000 people who live in East Toronto. Our communities are diverse, with our 'Network of Networks' model needed to tailor solutions needed across many of East Toronto's 21 neighbourhoods, ranging from the distinct needs of five designated City of Toronto Neighbourhood Improvement Areas (Thornccliffe Park, Victoria Village, Oakridge, Flemington Park and Taylor-Massey), to those of higher-income areas such as The Beach and Riverdale.

The ETHP reviewed a number of reports to understand population health, social determinants of health, primary care and broader health care utilization among the East Toronto core population, and across East Toronto providers. This review confirmed that, collectively, the members of the ETHP are the predominant providers of health care in East Toronto, serving a community with diverse needs:

- **Seniors and caregivers:** East Toronto has over 40,000 seniors (14% of the community), with a higher percentage of seniors living alone compared to the Toronto Central average. East End-Danforth and Thornccliffe Park populations include over 40% of seniors living alone. Caregiver distress is particularly high, at up to 47%, in specific East Toronto neighbourhoods.
- **People living with mental health challenges and addictions:** East Toronto has over 21% of its population, or 62,000, with mental health and addictions needs, and some areas have 3x higher youth mental health utilization in the emergency department than the Toronto Central average.
- **Priority Neighbourhoods to meet the local needs of diverse communities:** Analysis of multiple social determinants of health identified a need to focus on the over 90,000 residents living in priority neighbourhoods to address unmet needs – e.g. some communities in East Toronto have a high newcomer population (18.6%) compared to Toronto Central (5.5%).

These three Year 1 populations comprise approximately 150,000 unique individuals, or 50% of East Toronto. As we progress, we will expand our focus to perinatal and pediatric care in East Toronto, including existing integrated midwifery care models, and to integrated palliative care. Combined with an evolving primary care network, and integration of home and community care services, we will expand the ETHP and our community focus to the full population of 300,000 residents in East Toronto, at maturity.

Although this East Toronto catchment represents the majority of patients served by ETHP, our services are available to all Ontarians. We recognize patients who access primary care, mental health and addictions and acute care in East Toronto may reside outside of the catchment area. These patients remain a priority for the partnership.

For Year 1, ETHP selected priority populations identified in Module 1 of our self-assessment based on available population health data, local understanding of community needs, and ongoing engagement with patients and families. In future, we envision a membership model where individuals and families can choose to sign-up to be part of, and served by ETHP; in support, we will develop a digital solution to enroll and roster community members.

# Ontario Health Team Self-Assessment Form

## Model Component 4: In Scope Services

**At maturity**, Ontario Health Teams will provide a **full and coordinated continuum of care** for all but the most highly-specialized conditions to achieve better patient and population health outcomes as needed by the population.

Assess your team’s ability to meet the following requirements:	Yes	No	Partial
<ul style="list-style-type: none"> <li>Your team is able to deliver coordinated services across at least three sectors of care<sup>3</sup> and you have adequate service delivery capacity within your team to serve the care needs of your proposed Year 1 target population (e.g., your team includes enough primary care physicians to care for all Year 1 patients)</li> </ul>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>You are able to propose a plan for phasing in the <u>full</u> continuum of care over time, including explicit identification of further partners for inclusion</li> </ul>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>As part of that plan, you can specifically propose an approach for expanding your team’s primary care services to meet population need at maturity</li> </ul>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A

**Self-Assessment Scale for In Scope Services**

*Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.*

Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

<sup>3</sup> Prioritization will be given to submissions that include a minimum of hospital, home care, community care, and primary care (including physicians and inter-professional primary care models, such as family health teams, community health centres, and other models that feature a range of inter-disciplinary providers)



# Ontario Health Team Self-Assessment Form

## **Rationale (300 words maximum)**

*Please provide a rationale for your self-assessment response.*

The East Toronto Health Partners envision our Ontario Health Team as a “Network of Networks”, through “Anchor Partners”, “Engaged Partners” and “Supporting Partners”, all working together to deliver integrated service offerings to patients in East Toronto. Through our ‘Network of Networks’, the ETHP provides a full range of health and social services: From primary to quaternary acute care, food security to supportive housing, from birth to end-of-life, and settlement to employment. Our diverse mix of assets and resources enable our mission of supporting the complex health and social needs of those we serve.

At maturity, all health service providers and primary care practitioners will be linked to the ETHP. At the centre of care in East Toronto is the comprehensive primary care provided by the over 260 family physicians, nurse practitioners and midwives working in the region, who will be connected through our East Toronto Primary Care Network. The partners have a shared vision and commitment to embed and integrate the functions of care coordination into the ETHP, including long-term care placement.

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. 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.

*In addition to your scoring rationale, please identify the services you propose to provide to your Year 1 population. For each checked service, you must have adequate service delivery capacity within your team to serve the care needs of your proposed Year 1 target population (e.g., to check off ‘primary care physicians’ your team must include enough primary care physicians to care for your Year 1 population). Where relevant, provide additional detail about each service (e.g., which member of your team would provide the service).*

- primary care
  - interprofessional primary care
  - physicians
- secondary care (e.g., in-patient and ambulatory medical and surgical services (includes specialist services))
- home care and community support services
- mental health and addictions
- health promotion and disease prevention
- rehabilitation and complex care
- palliative care (e.g. hospice)
- residential care and short-term transitional care (e.g., in supportive housing, long-term care homes, retirement homes)
- emergency health services
- laboratory and diagnostic services
- midwifery services; and
- other social and community services and other services, as needed by the population (please provide more details below):

# Ontario Health Team Self-Assessment Form

## Model Component 5: Leadership, Accountability and Governance

**At maturity**, Ontario Health Teams will be self-governed, operating under a shared vision and working towards common goals. Each Team will operate through a single clinical and fiscal accountability framework.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• You have identified your partners and at least some partners on your team are able to demonstrate a history of formally working with one another to advance integrated care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• You are able to propose a plan for physician and clinical engagement and ensuring inclusion of physician and clinical leadership as part of the team's leadership and/or governance structure(s)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Your team is committed to:			
➤ The vision and goals of the Ontario Health Team model	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
➤ Putting in place a strategic plan or direction for the team, consistent with the Ontario Health Team vision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
➤ Reflecting a central brand	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
➤ Working together towards a single clinical and fiscal accountability framework	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
➤ Entering into formal agreements with one another	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A

### Self-Assessment Scale for Leadership, Accountability and Governance

*Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.*



Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

# Ontario Health Team Self-Assessment Form

## **Rationale (250 words maximum)**

*Please provide a rationale for your self-assessment response.*

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 builds 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.

We define three interconnected partner groups serving community members as the most critical and first partner in our “Network of Networks” model.

### **Anchor Partners:**

- Formal signatories of the OHT Application and ETHP
- Responsibility to work with and keep “engaged partners” included in co-design of ETHP work
- Define 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 ETHP through one or more anchor partners
- Kept informed and have input into decisions of ETHP
- Co-design care pathways as collaboratively defined by the ETHP and Engaged Partners
- 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)

### **Supporting Partners**

- Local providers, individual practitioners, 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

In addition, Dr. Kevin Workentin, as the Chief of TEHN’s Department of Family and Community Medicine, commits to engaging primary care physicians in East Toronto to develop a primary care network, and provide interim leadership with the ETHP to co-design our model for primary care centred integrated care. As the Primary Care Network evolves, it will take a strong leadership role, and will guide the engagement of individual and organized primary care practitioners across East Toronto.

Anchor organizations will be linked to health service and primary care providers in East Toronto. We intend to advance the “anchor partnership” model through a more explicit Joint Venture agreement, to be signed by our Boards of Directors by September 2019. In addition to dedicated leadership and operational meetings, our anchor partner Board leaders are beginning the discussion of governance oversight of our work, including how we continue to embed community members of East Toronto in the governance oversight of ETHP.

Through our “Engaged Partners”, we will co-design integrated programs that build health among our populations. They will 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.

# Ontario Health Team Self-Assessment Form

## Model Component 6: *Performance Measurement, Quality Improvement, and Continuous Learning*

**At maturity**, Ontario Health Teams will provide care according to the best available evidence and clinical standards, with an ongoing focus on quality improvement. A standard set of indicators aligned with the Quadruple Aim will measure performance and evaluate the extent to which Teams are providing integrated care, and performance will be publicly reported.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Your team can demonstrate that it has a basic understanding <sup>4</sup> of its collective performance on key integration metrics	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Each member of your team has a demonstrated history of quality and performance improvement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Your team has identified opportunities for reducing inappropriate variation and implementing clinical standards and best available evidence	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
• Your team is committed to:			
➤ Collecting, sharing, and reporting data as required	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
➤ Working to pursue shared quality improvement initiatives that integrate care and improve performance	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
➤ Engaging in continuous learning and improvement, including participating in learning collaboratives	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A
➤ Championing integrated care at a system-wide level and mentoring other provider groups that are working towards Ontario Health Team implementation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	N/A

**Self-Assessment Scale for Performance Measurement, Quality Improvement, and Continuous Learning**

*Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.*

Your team is able to meet fewer than 3 of the requirements above

Your team is able to meet all of the requirements above

<sup>4</sup> Each partner collects/reports data for and knows its own performance on at least some of the given metrics (or other similar metrics)

# Ontario Health Team Self-Assessment Form

## **Rationale** (250 words maximum)

*Please provide a rationale for your self-assessment response. Identify any shared indicators that are currently being measured or monitored across the members in your team.*

Quality and collective performance measurement are part of our vision. Across all of the East Toronto Health Partners, we work closely with patients, families, caregivers and our front-line clinicians to define what quality care means, monitor our progress, and continually improve together.

Beginning in fall 2018, we 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. Building on early efforts, we will work in Year 1 to enable data collection across EHP for our priority populations, by ensuring adequate tools and resources are in place.

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 addition, the Canadian Foundation for Healthcare Improvement (CFHI) recently accepted an application by a joint team across MGH, WoodGreen and VHA to the EXTRA Fellowship, for the Home 2 Day model. Through the EXTRA program, we will build on Home 2 Day'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 and Caregiver population, focuses our spread efforts on key change initiatives, and accelerates the impact of this initiative on population health outcomes.

We are champions and mentors to our peers on shared quality at a system-wide level, and already shared our implementation pathway with partners across the Province. Our CEO members regularly share our progress with a broad range of partners including speaking at Board retreats of community health service providers, enabling them to accelerate their own partnership and network models.

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, QI 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 EHP.

# Ontario Health Team Self-Assessment Form

## Model Component 7: Funding and Incentive Structure

**At maturity**, Ontario Health Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations. Teams that exceed performance targets will be able to keep a portion of shared savings. Teams will gain-share among members.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Each partner in the team is able to demonstrate a strong track record of responsible financial management <sup>5</sup> (this may include successful involvement in bundled care and management of cross-provider funding)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Your team can demonstrate that it has a basic understanding of the costs and associated cost drivers for your Year 1 population and/or proposed population at maturity	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Your team is committed to:			
➢ Working towards an integrated funding envelope and identifying a single fund holder	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
➢ Investing shared savings to improve care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Self-Assessment Scale for Funding and Incentive Structure**

*Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.*

<sup>5</sup> Examples of evidence that may suggest poor or declining financial management include: For hospitals - Balanced budget waivers due to deficit, operating pressures request history, cash advance request history, deteriorating working funds position, demonstrated difficulty in managing cross-provider funding as part of bundled care. For primary care (physician and non-physician models) - Non-compliance with their current contract, service accountability agreement and applicable public service procurement practices

# Ontario Health Team Self-Assessment Form

## **Rationale** (250 words maximum)

*Please provide a rationale for your self-assessment response.*

Through our proposed joint venture agreement, the ETHP commit to a joint financial accountability framework focused on common funding, shared opportunities for savings, and reinvesting savings to enhance patient care and services to the community.

In Year 1, our initial strategy focuses on priority populations, to advance our understanding of key cost drivers, seek efficiencies for reinvestment, and optimize resource sharing to best serve our community. This work to define our funding and incentive structures will be significant, but builds on early examples of funding integration across the partners:

- **Home 2 Day:** 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. Our expansion of the Home 2 Day program will focus on chronic diseases with similar opportunities to reduce costs and improve patient experience, linking to the CHC respiratory health partnership which contributes to the reduction of emergency room visits.
- **Participation in Bundled Care pathways:** MGH and Providence 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
- Each of the anchor partners also have **other clinical and fiscal accountability relationships** across our 'Network of Networks', which contribute to advancing the Quadruple Aim for our communities.

Across these initiatives, and more broadly for the Ontario Health Team in East Toronto, the CEO leadership of our anchor partners agreed in fall 2018 that Michael Garron Hospital would become a primary fund holder for the collective. This early agreement demonstrates our shared trust and commitment toward an integrated funding envelope for East Toronto. At maturity, we will shift to joint funding and accountability as ETHP.

# Ontario Health Team Self-Assessment Form

## Model Component 8: Digital Health

**At maturity**, Ontario Health Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience.

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Most partners in the team have existing digital health capabilities that are already being used for virtual care, record sharing <b>and</b> decision support	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Your team is able to propose a <b>comprehensive</b> plan to improve information sharing and resolve any remaining digital health gaps, consistent with provincial guidance regarding standards and services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Your team can identify a <b>senior-level</b> single point of contact for digital health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Self-Assessment Scale for Digital Health

*Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons.*



Your team is able to meet fewer than 2 of the requirements above

Your team is able to meet all of the requirements above



# Ontario Health Team Self-Assessment Form

## **Rationale** (250 words maximum)

*Please provide a rationale for your self-assessment response. Identify any common digital tools currently in use by the members of your team.*

The ETHP have a strong existing digital infrastructure and a history of connecting together. All anchor partners are capable of communicating securely (ONE Mail), and almost all have access to the ConnectingOntario Viewer; including early adopter primary care physicians in East Toronto. Patients who visit MGH can access their health information via MyChart, with plans for WoodGreen and South Riverdale CHC clients to have the same access. The anchor community agencies also have strong digital capabilities, including in community business intelligence. Community members in East Toronto can virtually connect with primary care (eVisit), and have access to a variety of virtual programs depending on their needs (e.g. Big White Wall, teleophthalmology, telehomecare, virtual care through Home 2 Day, specialist physician visits, and others).

A Digital Action Plan is in place to aggressively pursue digital maturity. This action plan is built on three concepts: digital connectivity, customer service, and an intelligent learning system. We have an initial focus on – but not limited to – the following initiatives:

- **Secure messaging** among providers, to improve communications across the health care team
- Ensuring all **citizens** have **digital access to information** and **virtual connection** with providers (e.g. via email, secure messaging, and/or digital records)
- Supporting **primary care providers** to overcome barriers to **connect**, leveraging provincial assets
- Optimizing **coordination of care at home** (eCCP, virtual care and other emerging technologies)
- Implementing **population health management** / CRM solution (and common patient roster)
- Leveraging Provincial Gateway for **information exchange**
- Establish data backbone for **analytics** and operational data modeling

Guided by the East Toronto Digital Committee, the partners commit to accelerate our shared digital maturity and ensure alignment of common tools.

# Ontario Health Team Self-Assessment Form

## Part III: Implementation Snapshot

*Please provide a high-level overview (maximum 500 words) of how you plan to implement the Ontario Health Team model and change care for your proposed Year 1 target population.*

*Include in your response:*

- Considering the quadruple aim, standard performance measurement indicators, and Year 1 Expectations for Early Adopters set out in the Ontario Health Teams Guidance for Health Care Providers and Organizations, what are your immediate implementation priorities?*
- What would you anticipate as key risks to successfully meeting Year 1 Expectations and how would you address them?*

We have the following priorities for our three Year 1 populations:

- Creating a service inventory and care navigation map for providers, patients and families
- Coordinating intake and access across the continuum of care
- Advancing 24/7 navigation to support patients and providers
- Developing Patient and Caregiver education supports
- Defining the integrated quality improvement plan and related quality and performance metrics

We will continue to advance the populations we serve at maturity, including existing integrated midwifery services; perinatal and pediatric care in East Toronto; and expanding integrated palliative care.

Our key risks to implementing an Ontario Health Team in East Toronto include:

- Leadership and operational capacity to drive ongoing strategy, project leadership and implementation of the ETHP; we will mitigate this by re-aligning existing resources across the anchor partners.
- Our vision of a 'Network of Networks', which requires that continued support from our partners; we will mitigate this through ongoing engagement of our partners, shared decision-making, and transparency.
- Ongoing health human resources challenges, especially due to Personal Support Worker (PSW) shortages, critical to our integrated care pathways; we will mitigate this through shared resourcing, digital solutions, and better alignment to our community's health needs.

ETHP is optimistic about how we can advance integrated care, but also recognizes the important role of the Ministry in supporting change management and accelerating several system-level funding and policy domains:

- **Support for Primary Care Network development**, toward our efforts in developing a 'first in Ontario' primary care network, and policy support to enable better collaboration (e.g. resolving negotiation to access bonuses, managed entry programs).
- **Integration of home care through** legislative, regulatory, and policy changes that evolve the role for home care service providers
- **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.

## Ontario Health Team Self-Assessment Form

- **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.

ETHP also has the following system-level priorities, advancing how we deliver the Quadruple Aim:

- Establishing the East Toronto Primary Care Network, its supporting governance and infrastructure
- Enabling an effective “Network of Networks” structure to involve providers across East Toronto
- Realignment of the Home Care Coordination function in East Toronto to the ETHP
- Implementing the Digital Priorities defined in our Year 1 Digital Action Plan
- Aligning funding and financial accountabilities for each of our Year 1 populations
- Recruiting a shared Mental Health and Addictions Director for East Toronto
- Formalizing ETHP governance, committees and our joint venture agreement by September 2019
- Defining how we will brand the ETHP, to create a unified identity in our community
- Determine how we will further engage the community, roster patients, and create membership in ETHP


Thank you for considering our ETHP self-assessment. We embrace this opportunity to innovate, and lead integrated care for East Toronto.

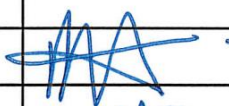
# Ontario Health Team Self-Assessment Form

## Part IV: Sign Off

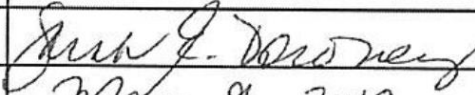
<b>Proposed name of the Ontario Health Team</b>	<b>East Toronto Health Partners</b>
<b>Primary contact for this application</b>	<b>Name: Anne Babcock</b>
	<b>Title: President and CEO</b>
	<b>Organization: WoodGreen Community Svcs</b>
	<b>Email: ABabcock@woodgreen.org</b>
	<b>Phone: 416-645-6000</b>

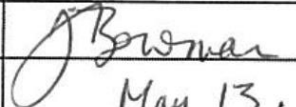
Please have **every provider or organization listed in Part I sign this form**. While Board approval is not required due to the short timeframe of the Assessment process, participants are expected to confirm the highest level of commitment possible.


Endorsed by	
<b>Name</b>	Anne Babcock
<b>Position</b>	President and CEO
<b>Organization</b>	WoodGreen
<b>Signature</b>	
<b>Date</b>	May 10, 2019

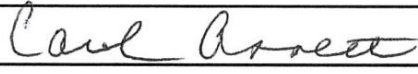
Endorsed by	
<b>Name</b>	Dr. Nicole Nitti
<b>Position</b>	East Toronto Primary Care Lead
<b>Organization</b>	
<b>Signature</b>	
<b>Date</b>	May 10 2019

## Ontario Health Team Self-Assessment Form


Endorsed by	
Name	Sarah Downey
Position	President and CEO
Organization	Michael Garron Hospital, Toronto East Health Network
Signature	
Date	May 9, 2019

Endorsed by	
Name	Jennifer Bowman
Position	Vice President, People and Transformation
Organization	Unity Health (for Providence Healthcare)
Signature	
Date	May 13, 2019

Endorsed by	
Name	Lynne Raskin
Position	Chief Executive Officer
Organization	South Riverdale Community Health Centre
Signature	
Date	May 10, 2019

Endorsed by	
Name	Carol Annett
Position	President & CEO
Organization	VHA Home HealthCare
Signature	
Date	May 10, 2019

## Ontario Health Team Self-Assessment Form

Endorsed by	
<b>Name</b>	Tess Romain
<b>Position</b>	Acting CEO
<b>Organization</b>	Toronto Central Local Health Integration Network
<b>Signature</b>	
<b>Date</b>	14 May 2019

# **Ontario Health Team East Toronto Health Partnership**

## **Supplemental Materials**

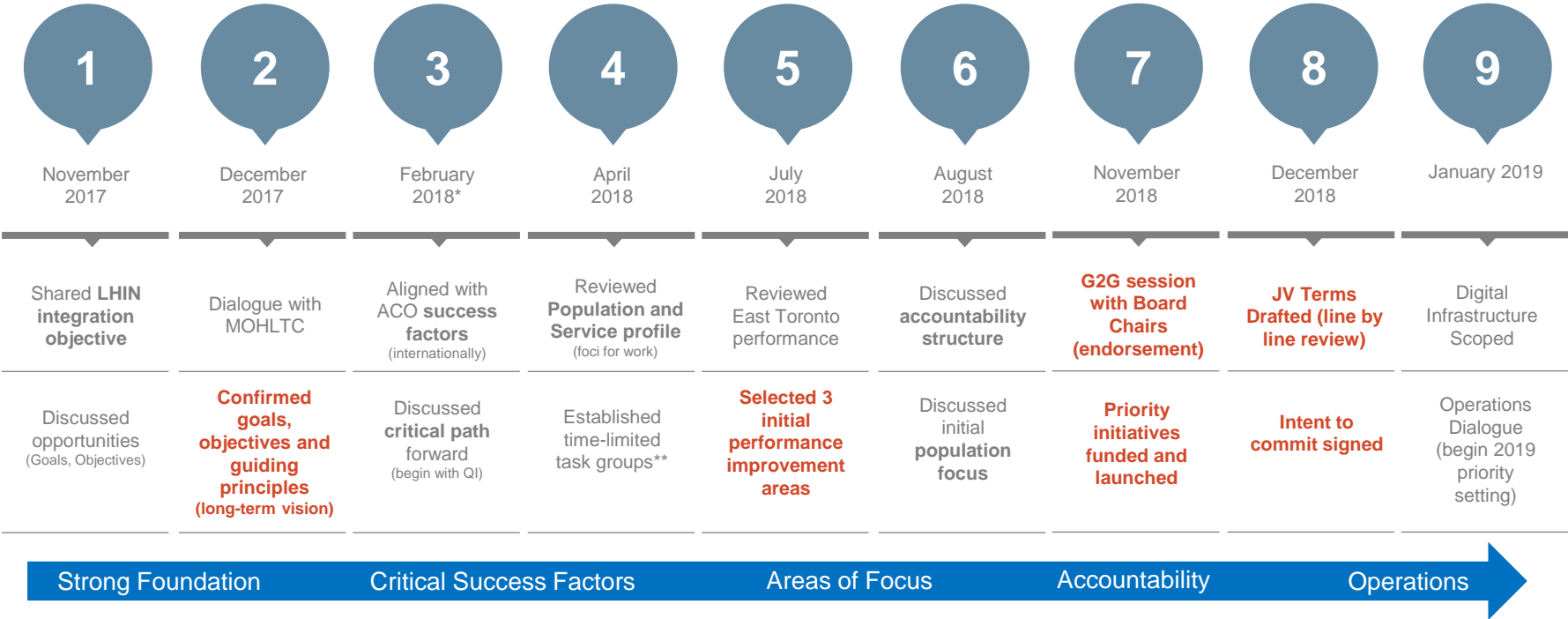
Self-Assessment Submission

May 15, 2019

# **Our Vision for East Toronto**



# Launched in November 2017, the East Toronto Health Partners have the momentum of trust and collaboration for an Ontario Health Team



\* March 2018 Facilitator Site Visits

\*\* May – June 2018 Time limited task groups to recommend performance improvement opportunities for 18/19

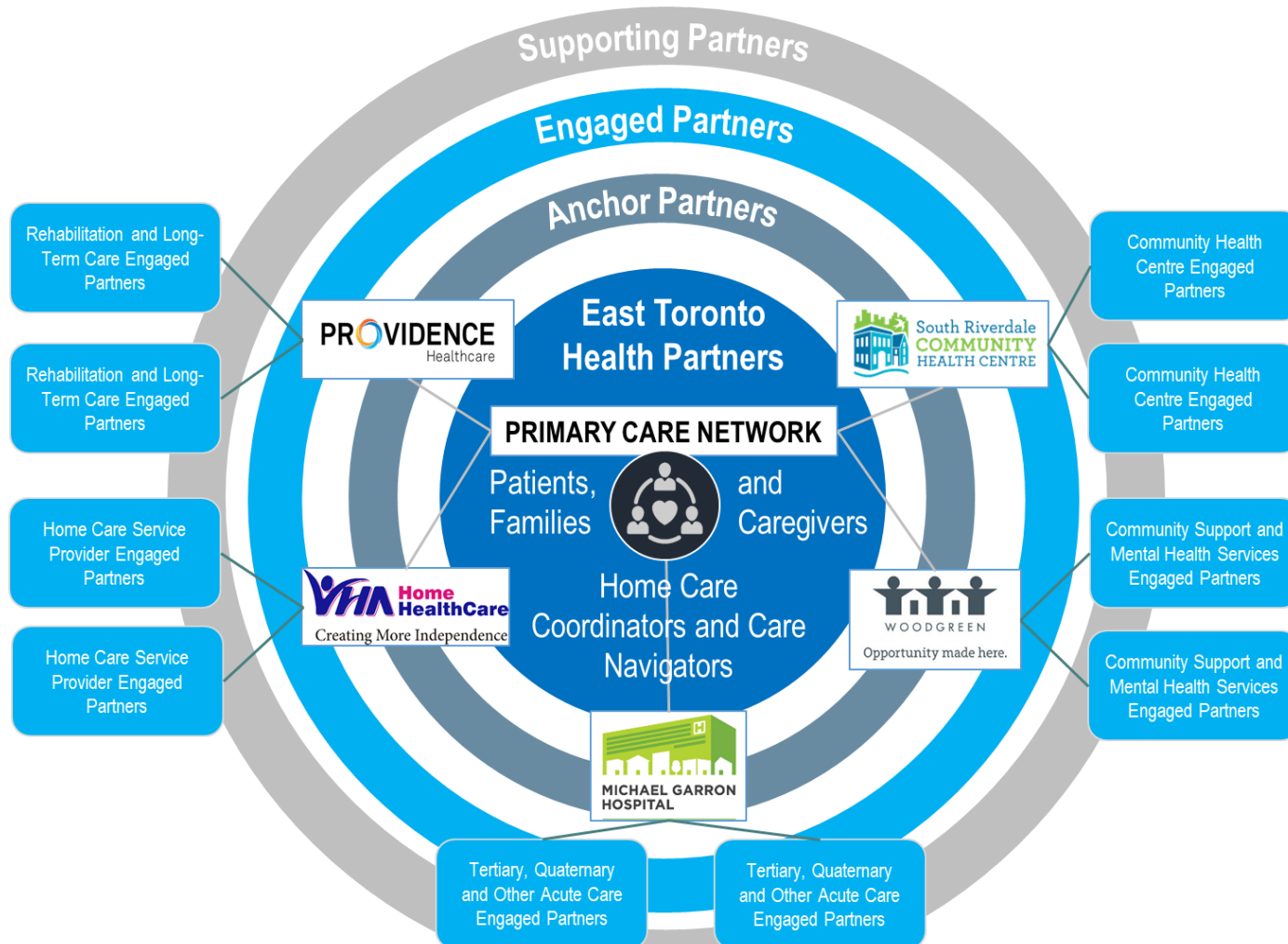
10 February 2019: Review JV and discuss digital infrastructure.

11 March 2019: Plan and set priorities for 2019.

12 May 2019: **Submit OHT Readiness Self-Assessment.**

# The East Toronto Health Partners will create seamless connected care for our community through a “Network of Networks”

*Community-focused anchor partners with long-standing collaboration on service integration through a joint venture with shared governance and resources, and fluidity in the role partners have in the network*



# ETHP is open to all partners committed to integrated care for East Toronto; Over 30 expressed interest as Engaged Partners

Hospital	CSS and CMHA	Home Care	Primary Care and CHCs	Long-Term Care	Other
<ul style="list-style-type: none"> <li>Sunnybrook Health Sciences Centre</li> <li>Sick Kids</li> </ul>	<ul style="list-style-type: none"> <li>East Metro Youth Services</li> <li>Turning Point Youth Services</li> <li>COTA</li> <li>St. Michael's Homes</li> <li>John Howard Society</li> <li>LOFT</li> <li>Massey Centre</li> <li>Gerstein Crisis Centre</li> <li>Warden Woods</li> <li>Centres d'Accueil Heritage</li> <li>Stella's Place</li> </ul>	<ul style="list-style-type: none"> <li>SE Health</li> <li>CBI</li> <li>Care Partners</li> <li>Closing the Gap</li> <li>Nurse Next Door</li> <li>Spectrum Health</li> <li>S.R.T. MedStaff</li> </ul>	<ul style="list-style-type: none"> <li>Dr. Kevin Workentin, the Chief of the TEHN Department of Family &amp; Community Medicine, which has &gt;100 Physicians members</li> <li>East Toronto Midwives</li> <li>Flemingdon CHC</li> <li>Access Alliance CHC</li> <li>East End CHC</li> <li>Scarborough Academic Family Health Team and Scarborough FHO (Dr. Michael Chu &amp; 17 Physicians)</li> <li>Dr. Catherine Yu, Health Access Thorncliffe Park</li> <li>Midtown FHO:               <ul style="list-style-type: none"> <li>Dr. Ruth Hussman</li> <li>Dr. Christine Hwang</li> <li>Dr. Dimitra Trambakoulos</li> <li>Dr. Celine Sandor</li> </ul> </li> <li>Dr. Karim Merali</li> <li>Dr. Karen Chu</li> <li>Dr. Mike Ramprasad</li> <li>Dr. Andrew Bond &amp; Inner City Health Associates</li> </ul>	<ul style="list-style-type: none"> <li>Sienna Senior Living – Harmony Hills and Fountain View Care Communities</li> <li>Nisbet Lodge</li> </ul>	<ul style="list-style-type: none"> <li>Toronto EMS</li> <li>ProResp</li> <li>The Neighbourhood Organization</li> <li>GTA Rehab Network</li> <li>Kids Health Alliance</li> <li>Philip Aziz Centre</li> </ul>

# Our partnership delivers a comprehensive basket of health and social services, tailored to meet changing local needs across East Toronto



Our joint venture brings together many of the health care and social support services that contribute to the social determinants of health in East Toronto

- Acute and Rehabilitation Care
- Home Care and Day Programs
- Long-Term Care
- Palliative Care
- Community Social Services
- Mental Health and Addictions
- Primary Care
- Food Security
- Friendly Visiting and Loneliness Services
- Employment Services
- Transportation
- Housing

# East Toronto Health Partners advance a shared vision for a ‘System without Discharges’, connected care built on early integrations

- **East Toronto Health Vision:** *A Seamless Continuum of Care that is Population Health-focused, with Programs Tailored to Local Communities*



**Chronic Disease  
Management and  
Home 2 Day**



**Integrated  
Mental Health  
and Addictions**



**Coordinated  
Primary Care  
and Home Care**



**Neighbourhood and  
Inter-professional  
Care Teams**



**Community  
Support  
Services**



**Integrated  
Surge  
Response**

**A Foundation of Integrated Health and Social Services for the Community**

**Streamlined Access and Navigation, Enabled by Digital and Virtual Care**

**Coordinated Governance, Resource and Performance Management**

# With Over 70 Health System Stakeholders and Patient Partners, We Established Shared Goals for the East Toronto Health Partners

The shared goals help **focus the integration efforts** for the East Toronto OHT and the region to **BE BOLDER, THINK DIFFERENTLY, and DO DIFFERENTLY.**

1. Everyone will know how to **access and navigate** health care in East Toronto
  - Navigation will be made easier for patients, caregivers and providers allowing for the **transition of patients to appropriate care settings**
2. Every person will have **timely access to culturally competent primary and inter-professional care** when needed for the patient
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
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                      Track **value**
  - Reflect **patient and community experience**                      Be **transparent and public**
7. Providers will be jointly committed to **continuous improvement** and **connecting with social services**
  - We will continuously **innovate** and **activate digital enablement** of care delivery in the region while building on existing elements of care and partnerships in the region
  - One collaborative Quality Improvement Plan (cQIP) will be published
  - As a network, will actively engage partners to contribute to **improving care across all 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

# ETHP and our Stakeholders also Designed Principles to Help Achieve the Shared Goals



## Community Centered

We are **guided by the needs of communities and the people we serve** (community over organization)

- Build a system that responds to what we have heard and provides equitable access for all
- Respectfully engage residents/patients, caregivers and communities to deliver culturally competent care
- Respect diversity (guided by the citizen voice) and maximize equity (inform investments)



## Provider Engagement

**Engagement with primary care and other providers** to inform the design of an OHT for the East Toronto region

- Engagement of clinical leaders in the design of care delivery models



## Integration of Services

Engage and activate the **health and wellness services** in the East Toronto region to **deliver holistic population based care**

- Partner with and integrate social services that in the region
- Social determinates of health need inform the care model to complete and strengthen the integration of care



## Inclusive & Transparent

Process will be **inclusive** and **transparent** both within the participant membership and with our partners in our communities

- Will be implemented through a collaborative / participatory model and on a voluntary basis
- This is a system approach
- Committed to consistency in messaging and how we communicate



## Effective Leadership

Success will **require strong and engaged leadership** for the OHT

- The OHT should have a unifying vision to guide the region
- Scope and values of competing priorities in the region should be aligned



## Continuous Improvement

Implementation will be underpinned by a willingness and **commitment to learning and continuous improvement (rapid adaptation)**

- This is an evolving / evolutionary process where failures should be used as learning opportunities for continuous improvement
- Development is evidence-informed and will be supported with timely evaluation
- Knowledge sharing across the region through Centres of Excellence (CoEs)



## Building on Success

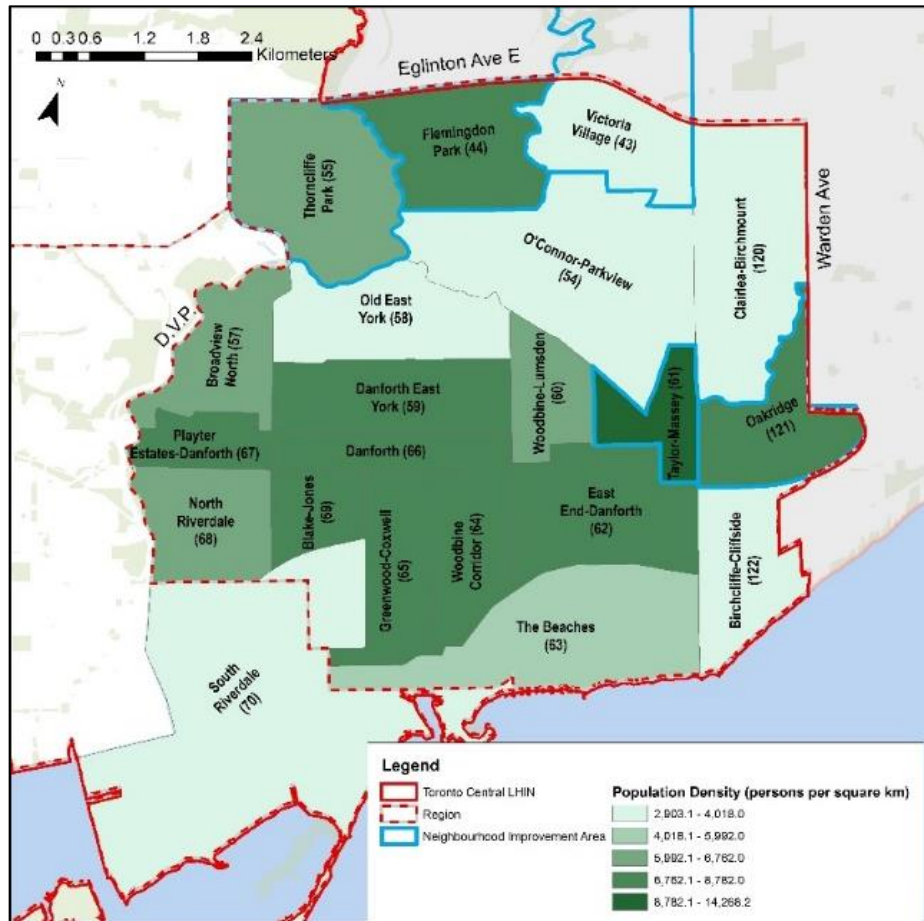
We will **capitalize and build on what has been accomplished to date**

- Integrate the digital systems in the region across the continuum of care to help coordinate care and share information amongst providers and with patients
- Adopt values defined by the Local Collaborative (person-centred, transparent, cooperative, inclusive, leading change)

# Engaging with the Community We Serve



# East Toronto is prime for integration as an Ontario Health Team, with diverse communities, well positioned for integrated care



- East Toronto has a population of 296,265
- There are 21 Diverse Neighbourhoods, with 5 Designated Neighbourhood Improvement Areas – needing a more focused effort on chronic disease:
  - Thorncliffe Park, Victoria Village, Oakridge, Flemingdon Park and Taylor-Massey
- Further, East Toronto has higher Mental Health and Addictions needs than the TC LHIN average: E.g. Taylor Massey has a 3X higher youth mental health utilization in the Emergency Department than TCLHIN

# East Toronto has lower socioeconomic demographics, and higher health care needs, giving focus to early engagement efforts of EHP

Population (2016)

**296,265**

Population Density: 6,889.9 ppl / km<sup>2</sup>



(M) 48.4% (F) 51.6%



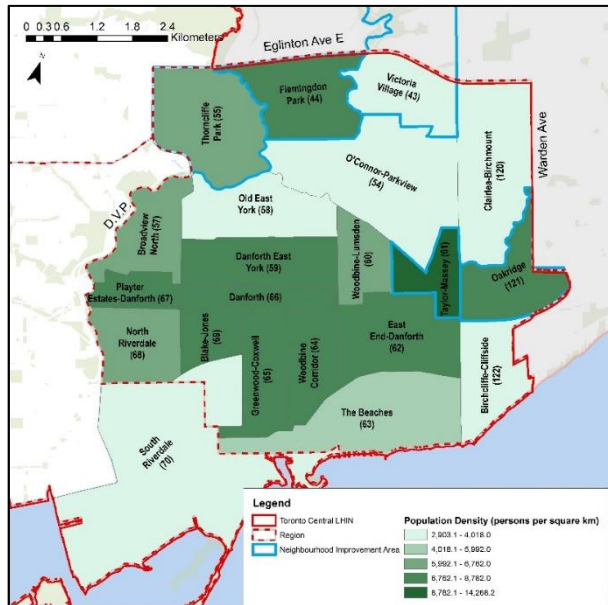
Child/Youth (ages 0-19): 22.7%

Seniors (ages 65+): 13.5%

**21 Diverse Neighbourhoods**

**5 Designated Neighbourhood Improvement Areas:**

Thornclyffe Park, Victoria Village, Oakridge, Flemingdon Park and Taylor-Massey



## East Toronto Neighbourhood Highlights (By neighbourhood ranges)

### Health Service Utilization

ED Visit Rates per 1,000 Population (2015/16 to 2016/17)  
**265.9 – 445.0**

Toronto Central LHIN:  
**322.1**

Hospitalizations for Prenatal, Delivery and Postnatal Conditions per 1,000 Population (2015/16 to 2016/17)  
**31.0 – 64.6**

Toronto Central LHIN: **36.6**

Mental Health and/or Addiction-related Hospital Admissions per 1,000 Population (2015/16 to 2016/17)  
**2.7 – 20.5**

Toronto Central LHIN: **6.6**

Caregiver Distress (2017/18)  
**26.7% - 47.4%**

Toronto Central LHIN: **34.2%**

### Sociodemographics

Low Income Measure, after-tax (2016)  
**9.3% – 45.5%**

Toronto Central LHIN:  
**19.0%**

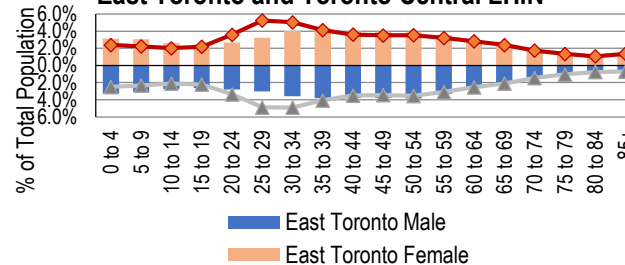
Recent Immigrants (2011-2016)  
**1.6% – 18.6%**

Toronto Central LHIN: **5.5%**

% No Knowledge of English/French (2016)  
**0.2% – 8.1%**

Toronto Central LHIN: **3.5%**

### Population by Age and Sex Distribution in East Toronto and Toronto Central LHIN



Neighbourhood Population Range  
**7,735 – 27,870**

High Age Groups relative to Toronto Central LHIN: 0-19 years

### Health Status

Children Vulnerable on 1+ EDI Domain (2015)  
**10.4% – 44.9%**

Toronto Central LHIN: **26.9%**

Birth Rate per 1,000 Population (2012/13 to 2014/15)  
**8.9 – 18.4**

Toronto Central LHIN: **10.3**

High Blood Pressure, Age 20+ (2016/17)  
**15.6% – 26.7%**

Toronto Central LHIN: **19.3%**

Diabetes, Age 20+ (2016/17)  
**5.6% – 16.9%**

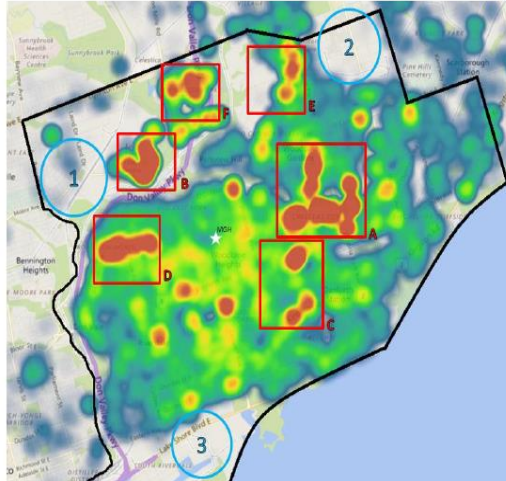
Toronto Central LHIN: **9.2%**

# Building on evidence, the East Toronto Health Partners use data on local health needs and health system utilization to target solutions

## Examples of East Toronto Integration Efforts

- Recent surge efforts invested \$1.5M in the community to improve access to primary care, health and social services in East Toronto
- Piloting integrated Mental Health and Addictions leadership

ED Visits within MGH Catchment Area (Heat Map)



Low Density Visit Areas

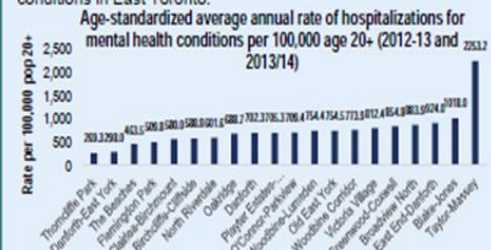
1. Leaside/Bennington
2. Clairlea-Birchmount
3. Lower Don Lands / Port Lands

High Density Visit Area

- A. Apartment Complexes (Crescent Town, Main Square)
- B. Thorncliffe Park Residential Apartments
- C. Danforth Village
- D. Cosburn Apartments
- E. Nursing Home/LTC/Small Apartment Complex
- F. Flemingdon Park

## Why This Opportunity Was Identified

Taylor-Massey has the highest hospitalizations for mental health conditions in East Toronto:



Taylor-Massey has the second highest proportion of low income population in East Toronto:

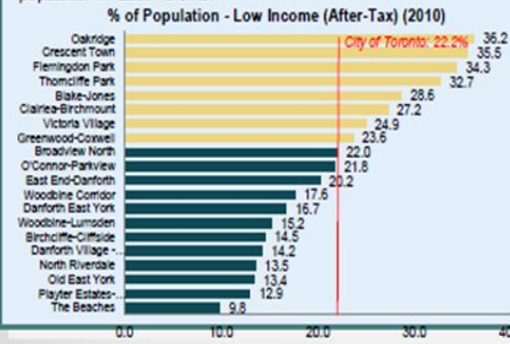
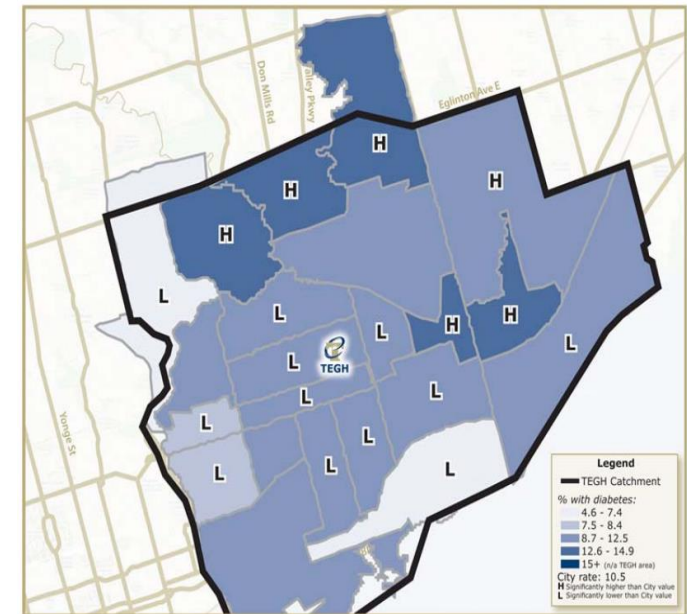


Figure 12: Diabetes Rates 20+ in the TEGH Catchment Area



## **ETHP will build on long-standing commitment across all partners to partner and co-design with our community**

- Michael Garron Hospital engages community members in co-design of targeted care models, monitoring of key initiatives such as our redevelopment, involvement in leadership recruitment, and more. We also have a Community Advisory Council that guides us on broad strategic issues, and which endorses the East Toronto Health Partners.
- South Riverdale CHC engage patients in all aspects of co-designing their care, including chronic disease programming. Recently, SRCHC engaged drug users in Danforth East, facilitating a conversation with over 40 community members to determine their needs. SRCHC also has two indigenous health promoters working in our services for people who use drugs, integrating traditional practices with harm reduction services.
- At WoodGreen, caregivers are full partners in change ideas through Experienced Based Co-Design. We have continually captured caregiver experiences through interviews, focus groups and an all-day summit highlighting the theme “How might WoodGreen become caregiver friendly every time?”
- Providence Healthcare has a long history of engaging with patients, residents and families. In addition to long-standing Resident Councils, there are 34 active advisors involved in work ranging from planning workshops, to care model design, to leadership recruitment, and other initiatives.
- VHA has a Client and Carer Advisory Council and over 60 client and family partners, representing a variety of cultures, age groups, experiences and geographies. Client and Carer Advisors work together with VHA staff and service providers to co-design services and processes, inform hiring, and also get engaged in research.
- Priority Neighbourhoods: Health Access Thorncliffe Park is an example of effective engagement of residents, schools, and grassroots community groups in co-designing solutions resulting in improved integrated care for the local community.

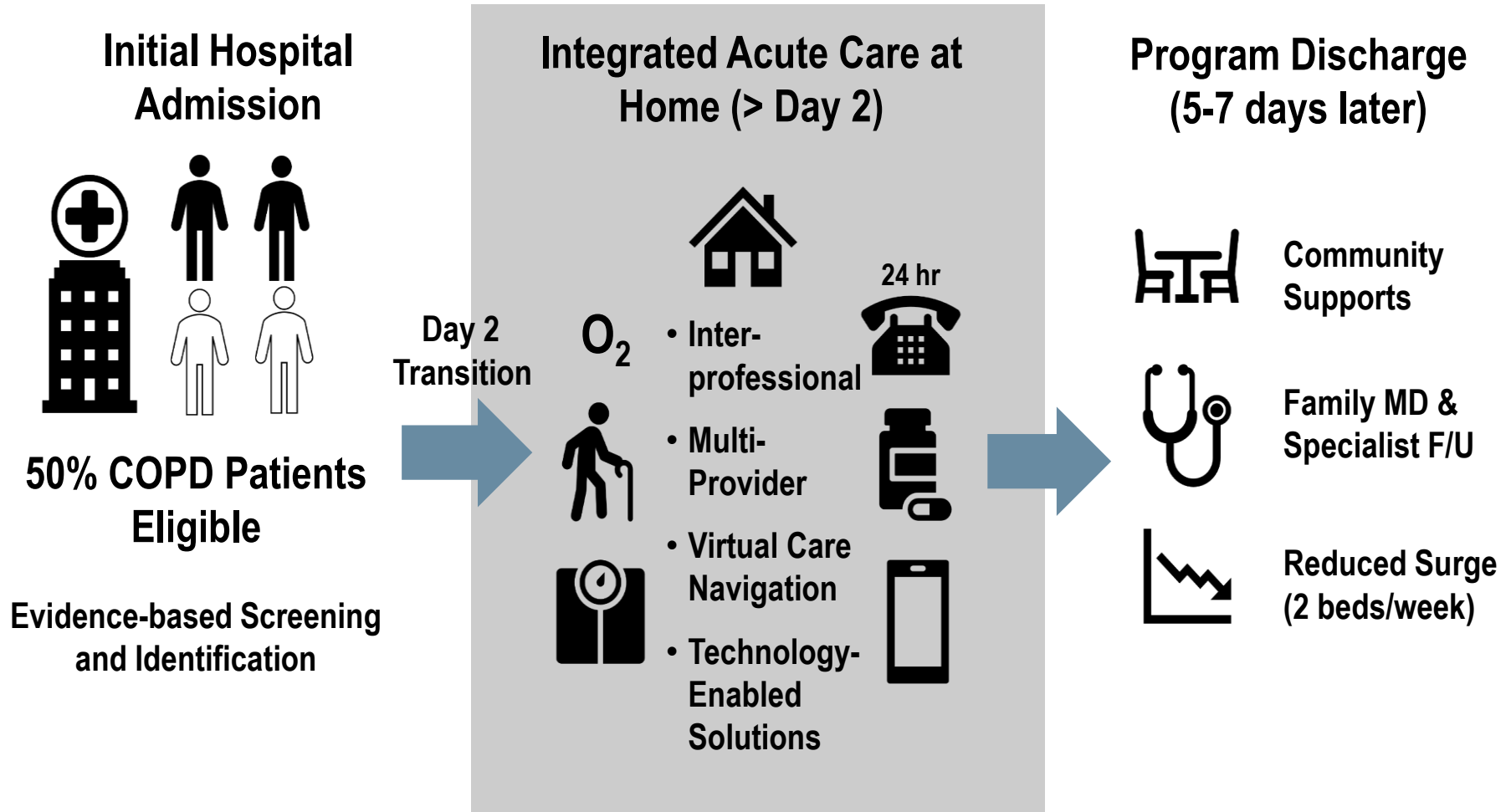
# Examples of Early Successes

# Integrated Surge Response: A collaborative investment of \$1.5M into tailored health and social services for East Toronto



- In response to winter surge, East Toronto Health Partners invested \$1.5M into a range of hospital and community-based services to better meet the needs of our local community:
  - **Expanded primary care after-hours clinics** → at Albany Clinic and in Thorncliffe Park
  - **Community outreach to vulnerable populations** → including shelter and other settings
  - **Neighbourhood-based flu vaccinations** → in several supportive housing areas
  - **Support to congregate food security** → enabling continued food services
  - **Enhanced weekend home-care services** → streamlining transitions home on weekends
  - **Local reactivation services in the community** → with coordinated transition and home care
  - **Expanded emergency department services** → reducing wait times and hallway health care
  - **Initiation of Home 2 Day for COPD patients** → a new hospital at home model in East Toronto
- Early evaluation insights demonstrate that surge investments supported important tests of change, enabled new models of care that will continue beyond surge funding, and continued to build on the momentum of trust across the ETHP

# Integrated Chronic Disease Management: Home 2 Day provides seamless virtual care, transitions and navigation for individuals



# The Youth Wellness Centre and Drop-in provides integrated health and social services, co-designed with local youth



The partners engaged 60 individuals (20 young people, 20 Youth workers and 20 youth mental health professionals) to identify how the Centre can address key issues in Youth Mental Health



WOODGREEN  
Opportunity made here.

1

## Youth Cafe

A place where youth can meet friends, hang out and participate in recreational activities.

Youth can access mental health support without the stigma of entering a more clinical space.

Integrated with other services and community partners (e.g. employment and skills training)



2

## What's Up Walk-In Clinic

Mental health counselling walk-in service for children, youth, young adults, and families.

The clinic helps with issues such as depression, anxiety, self-harm, suicidal ideation, sexual identity matters, bullying, behavioural concerns, and addictions



3

## Multi-sector support

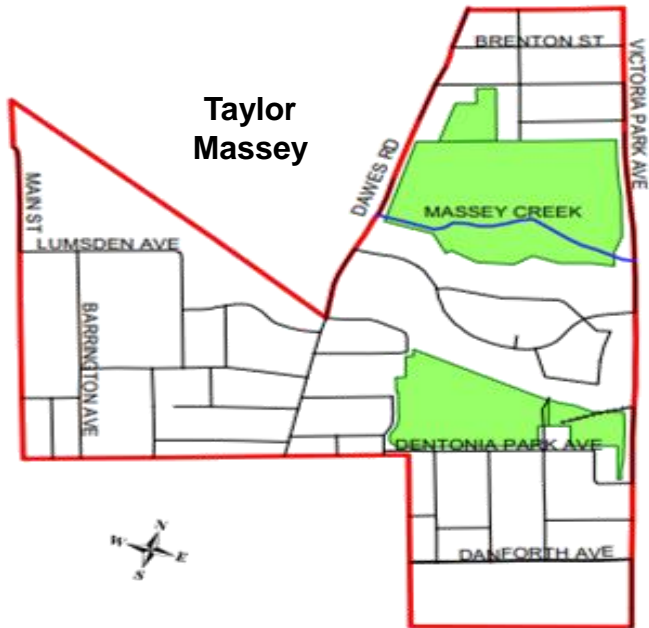
Michael Garron psychiatrists provide clinics and see patients' and families.

Inter-professional support to the walk-in counselling service.

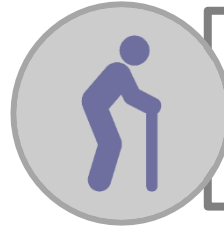
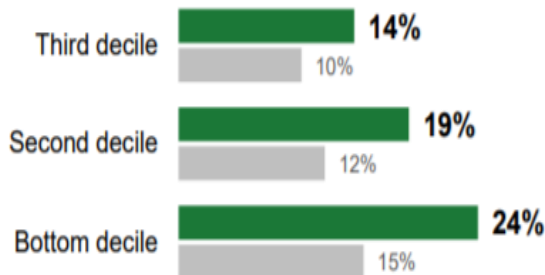
Partner agencies will have staff on site to provide additional services.



# Neighbourhood Care Teams: Taylor Massey is a community with high sociodemographic needs, requiring a tailored local approach



Economic family income by decile group



**33.1% of Seniors Living Alone\***

Compared to City of Toronto rate of 26.7%

2016 Listed 445 Seniors from 65 to 85 and 70 people 80+



**77.2% live in Apartments 5 stories or Above\***

Compared to City of Toronto rate of 44.3%



**11.5% Unemployment rate\***

Compared to City of Toronto rate of 8.2%



**47.4% Report Very Good or Excellent Mental Health ^**

Compared to City of Toronto Rate of 73.4%

# Neighbourhood Care wraps tailored, integrated health and social care around community members



## East Toronto Health Partnership Assets Leveraged



Primary Care



Caregiver Support



Employment



Dementia



Case Management



Financial Empowerment



Mental Health Nurses



Settlement



Counselling

## Critical Success Factors

Common Assessments



Support to define Privacy and Circle of Care



Cultural Specificity



Connect with Grassroots Agencies

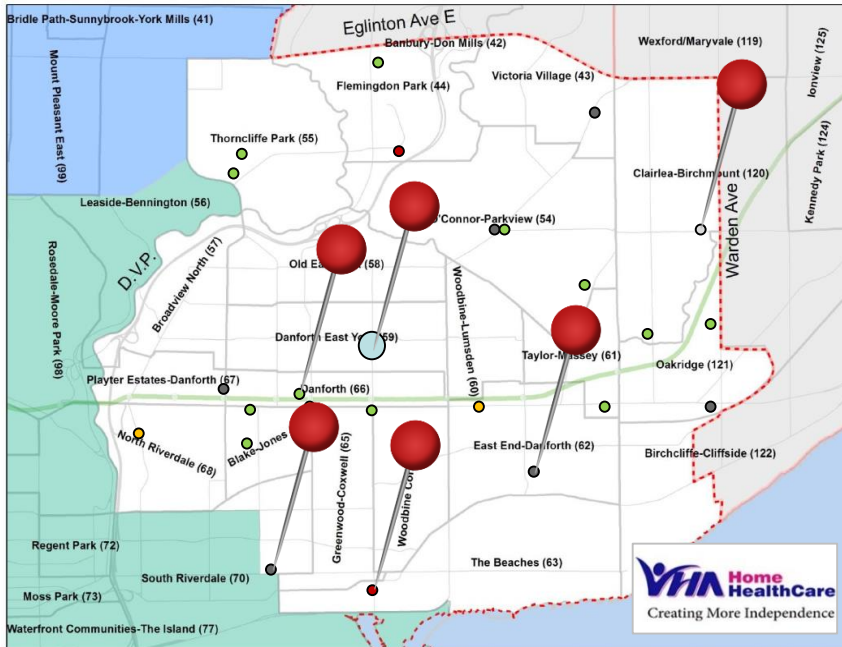


# Advancing our Digital Connectivity

# We Will Build on the Current State of Digital Connectivity in East Toronto to Achieve our Vision



Digital connectivity can be characterized by the ability to share PHI across care settings, organizations, providers and with patients using one or more integrated digital solutions.



1. It is assumed that Michael Garron Hospital will operate as the central hub given its infrastructure, capacity, and readiness to support an integrated delivery model of care.
2. Numbers and relative percentages are estimates based on limited 2017 MOHLTC census data and require validation.

Here's what digital connectivity looks like in East Toronto at present...

- **One hospital network with mature digital infrastructure** (Michael Garron, EMRAM level 6)
- **All acute-care data contributed to ConnectingOntario** to establish a provincially shared electronic health record (EHR)
- **100% patient ADT information shared** with primary care and Home & Community Care (eNotification)
- **Comprehensive Hospital reports shared** with primary care providers (**HRM**)
- **52% primary care providers use an EMR** in their practice and **80% of these also have access to one or more provincial digital health data assets** (e.g., ConnectingOntario, OLIS)
- **100+ primary care providers** have access to **ConnectingOntario** and **eConsult**
- Electronic **referral pathways** for hospital to rehab, Home & Community Care, acute, and LTC are live (RM&R)
- LTCH, CSS, and CMHA organizations all have **access to a repository for standardized client assessments** (IAR)
- **Patients can access** their personal health information digitally (MyChart), and some **receive virtual care** (eVisits, teleophthalmology, telehomecare, home 2 day program)
- **19 community organizations** use a client management system
- **Electronic Coordinated care plan** (eCCP) to be deployed at **4 organizations**, and CHRIS/HPG as an asset to leverage
- **All partnered organizations** have access to **secure email** (ONE Mail)
- All partners have an **enterprise data warehouse**, and **predictive analytics model** for ED forecast implemented at MGH

# Based on Evidence, EHP has a Draft Vision for a Digitally-Enabled Health Network

## What the Research Says:

- Patients' clinically relevant **information is available to all providers at the point of care and to patients** through shared electronic health record systems.
- **Patients have easy access to appropriate information and providers** in a timely and flexible manner that suits their needs. This includes access to a **single digital solution for viewing personal health information** and a mechanism to securely communicate with their care team (patients AND providers).
- Healthcare services and delivery can be performed in the **comfort of a patients' home**, when and where possible.
- Data allows for the **system to continuously innovate and learn** in order to improve the quality, value, and patients' experiences of health care delivery. All types of data will be connected and used to inform and predict future needs of the population and individuals.

**Three** ideas that encapsulates the vision of a Digitally-Enabled Integrated Care Delivery System:



### 1. DIGITAL CONNECTIVITY

Seamless exchange of information  
Secure messaging capabilities



### 2. CUSTOMER SERVICE

Population and individual-level insight  
Flexible virtual care solutions



### 3. INTELLIGENT (AND LEARNING) SYSTEM

Predicting needs  
Operational efficiencies  
Evidence-based planning

Adapted from: Shih et al. 2008. Organizing the U.S. Health care Delivery System for High Performance. The Commonwealth Fund: Commission on a high performance health system. [http://www.dphu.org/uploads/attachments/books/books\\_1024\\_0.pdf](http://www.dphu.org/uploads/attachments/books/books_1024_0.pdf)

# A Future State: Meredith's Story

## With Some Investment, EHP will Leverage Existing Provincial and Local Assets to Deliver on a Future State of Digital Interoperability

1. Meredith is part of a community agency that helps her manage her pre-existing conditions, with an **electronic care plan** that all can see.

2. She receives home care from a neighbourhood team that knows her story and can see her journey as a patient

9. Her social worker receives a notification of the ED visit, through CAN EMS



7. PCP reviews her discharge summary in an EMR (via **Health Report Manager**)

8. PCP wants a cardiologist's opinion, so a message is sent via **eConsult** through EMR. Upon hearing back, a secure message is sent to Meredith, to discuss outcomes and next steps



65 year-old, woman living alone in East Toronto, with a history of hypertension and diabetes.

She is a part of community programs that teach seniors about technical literacy, nutrition, etc.

She is **digitally registered** as part of the EHP OHT.

3. At the advice of her Primary Care Provider (PCP), through an **eVisit**, Meredith downloads a **consumer health app** to support self-care

4. After reviewing her lab results on **MyChart**, she **sends a secure message**, and goes **online to book** an appointment with her physician



5. Before she is able to meet with her PCP, she experiences sharp chest pains, and is presented to Michael Garron ED. Upon arrival, ED clinicians pull up her complete medical history (e.g. **ConnectingOntario**)

6. An **eNotification** about her visit to the ED is sent to her PCP's existing EMR



- Meredith interacts through a **consistent interface** with a common user experience
- She can **communicate freely** with her providers and care team and digital tools help her **manage her care at home**
- She **tells her story once** – a CRM shares life details to those in her circle of care

- Providers use **multiple tools**, but in an **integrated** way that **streamlines** and fits their **clinical workflow**
- There is a **seamless connection of information** between health team, including specialists, primary care and providers in the community
- Providers can **communicate** with each other and **coordinate a plan** around Meredith, and that plan can be seen by everyone that should see it

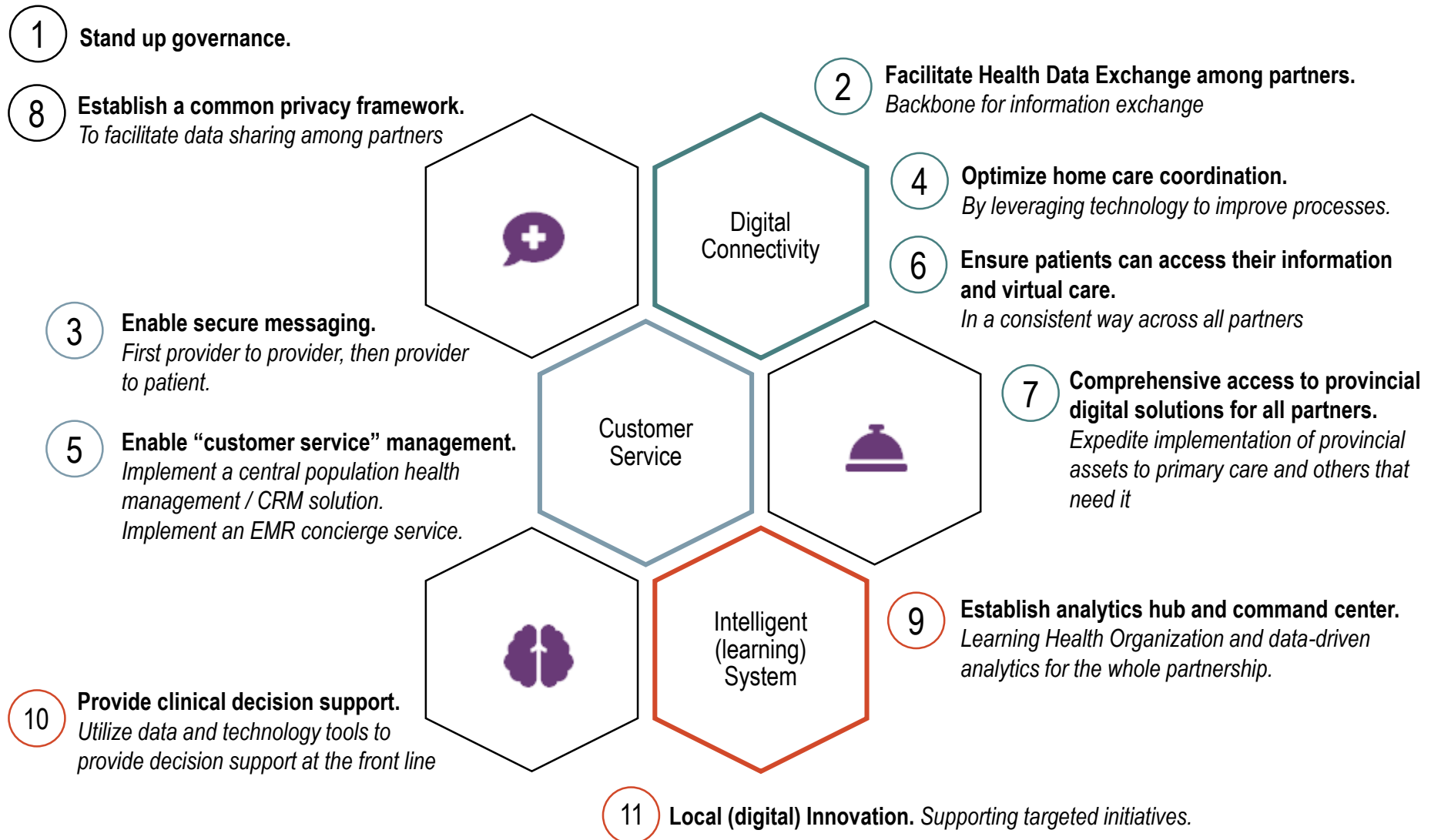


**Predictive Analytics** – Helps predict ED volumes for hospital to better plan and reduce wait time for Meredith  
**Business Intelligence and Reporting** – All partners use evidence to improve her access and experience

# ETHP's Guiding Principles for Future Digital Connectivity Focuses on Patient Choice, and Enabling Integrated Care

1. Leverage what exists (relationships, technology, data, agreements, etc.), where possible
2. Technology solutions must align with clinical workflow to ensure meaningful use, adoption, and sustainability
3. PHI/PI exchange occurs seamlessly and in real-time across the care continuum (including with patients)
4. Liberation of data is a key underpinning, and tools must be in place to enable this (i.e. data sharing, common identity management), and not be barriers
5. This work must not create more/new silos of care/information
6. Patient choice is maintained (e.g., for digital access to health information, services)
7. Patients must have a single gateway to access the health system and are afforded a single care team that is connected, coordinated, and work collaboratively.

# A Digital Action Plan Guides How EHP will Achieve its Vision





# Through our Vision and Action Plan, EPHP will Advance Digital Maturity

OHT guidelines for Digital Health

## Current Readiness

Demonstrated ability to digitally record and share information with one another and to adopt / provide digital options for decision support, operational insights, population health management, and tracking / reporting key indicators. Single point of contact for digital health activities. Digital health gaps identified and plans in place to address gaps and share information across partners.

## By Year 1

Harmonized Information Management plan in place. Increased adoption of digital health tools. Plans in place to streamline and integrate point of service systems and use data to support patient care and population health management.

## At Maturity

Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements and better patient experience.  
 "... [OHT] will offer patients digital access to their health information and a variety of options for virtual encounters..."  
 "... tools will also significantly improve the operations of health service providers and organizations, enabling improved workflows and reducing common day-to-day challenges that result in provider frustration and burnout."

### Self Assessment

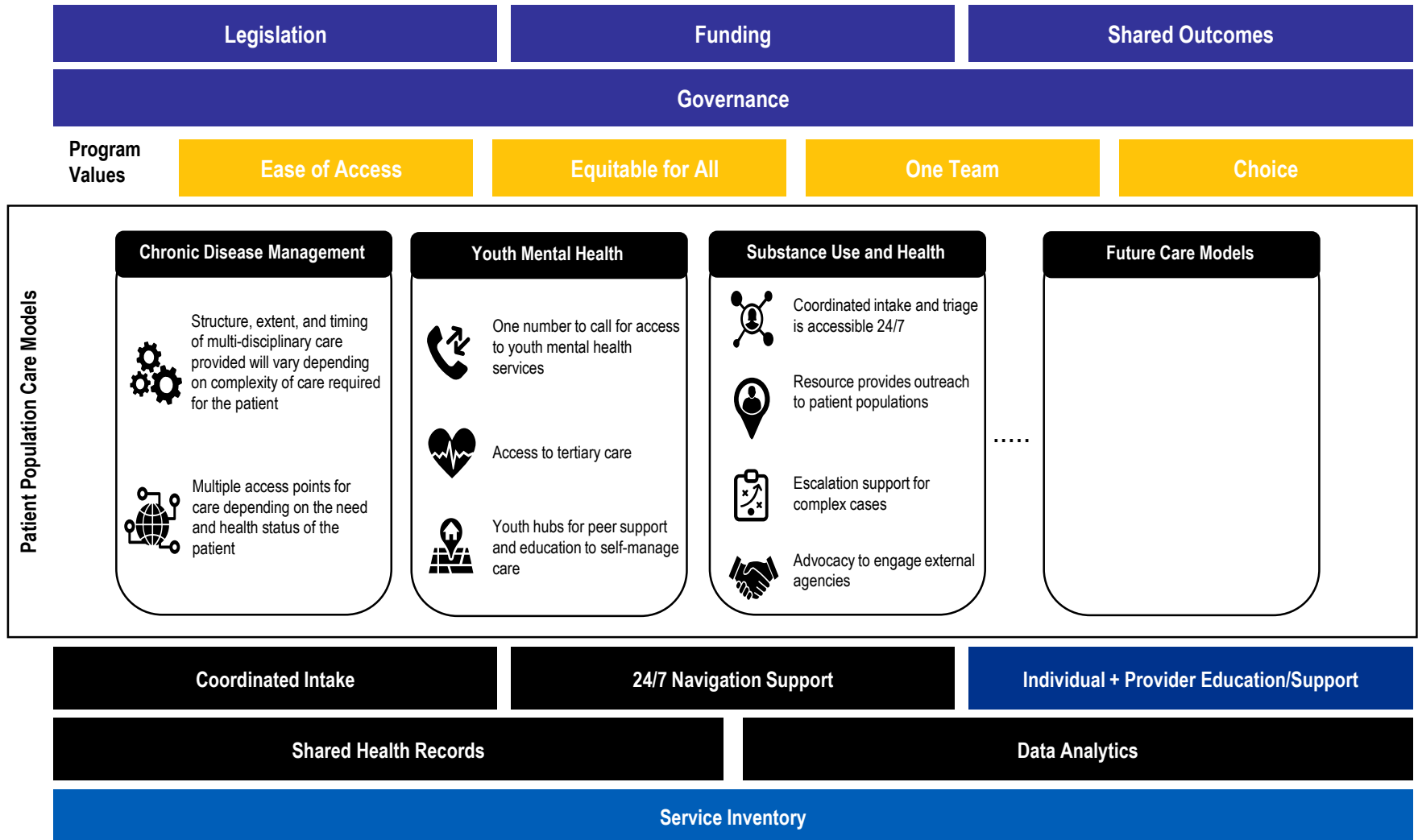
- ✓ All anchor partners have an EMR and ONEMail
- ✓ Almost all partners have ConnectingOntario
- ✓ HRM and eNotifications allows MGH to share information with PCPs
- ✓ Virtual programs in place to leverage and expand
- ✓ MyChart adoption
- ✓ Predictive modeling of ED visits at MGH
- ✓ Single point of contact for digital health activities have been identified
- ✓ Digital governance established
- ✓ Initial action plan developed

### In progress:

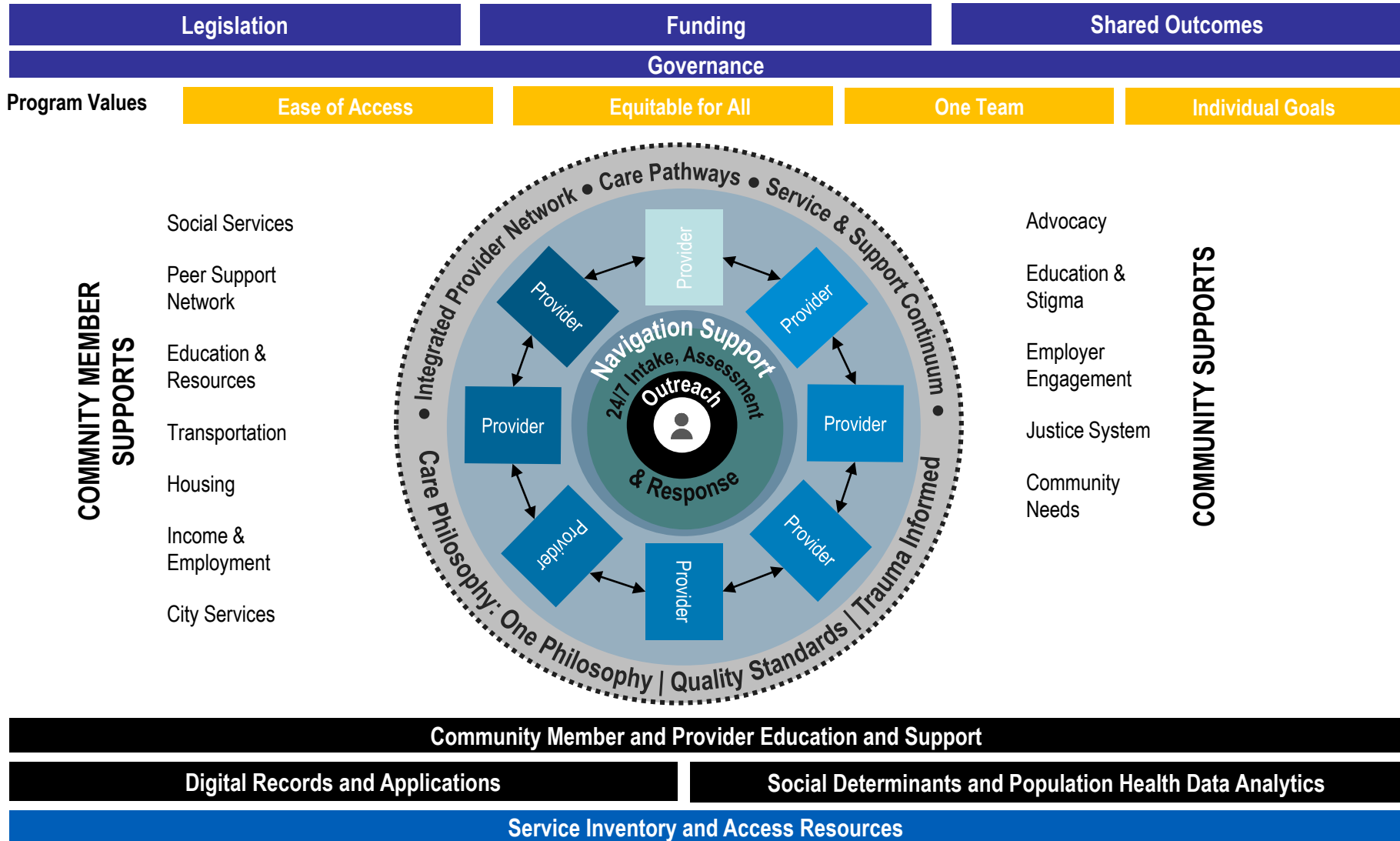
- Continued adoption of provincial assets for East partners
- Continually partner with PCP to ensure that new technologies align with clinical workflows and do not become a financial / administrative burden
- MyChart expansion
- Increase adoption of existing virtual solutions
- Exploring harmonized privacy framework, CRM / Population management solution, secure messaging

# Implementing the ETHP Health Team

# Supporting the Year 1 Populations, EHP engaged over 70 provider stakeholders and patients to define a High-level Reference Model



# At the population level, stakeholders also designed the Future State Model: An example for Substance Use and Health

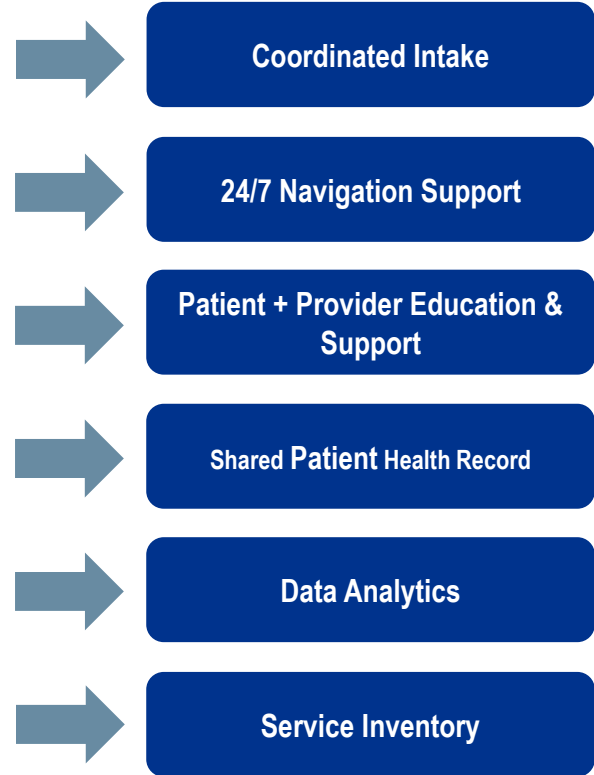


# Key challenges in the current state informed the Key Design Elements of each Future State Model

## *The current system lacks:*

- 1 A coordinated approach with central intake, triage, and case management capabilities. This leads to poor communication with the patient regarding their care, causing them anxiety/distress.
- 2 Immediate access or navigation for patients across their continuum of care.
- 3 Cultural competence in delivery of care; Capability to manage complex cases; Ability of patients to self-manage their care; Awareness on services available throughout the continuum of care.
- 4 Availability of integrated and consistent patient health information amongst all providers and with the patients.
- 5 An evidence based approach to delivering care for the East Toronto patient population.
- 6 A way for patients, caregivers and providers to access information on healthcare and wellness services available in the East Toronto region.

## *The future model will provide:*



*Other challenges in the current state that are more specific to a patient population informed the design of their respective conceptual future state model.*

# Supporting coordination and integrated service delivery at the local level, EHP now has Care Coordinators aligned with neighbourhoods across East Toronto

East Community Care Team



# The East Toronto CHCs envision a Networked Approach to supporting team based primary care

## OPPORTUNITY FOR AN EAST TORONTO PRIMARY HEALTH CARE NETWORK

**ACCESS ALLIANCE, EAST END CHC, FLEMINGDON HEALTH CENTRE & SOUTH RIVERDALE CHC**

**TIMING: NOW**

**ADDITIONAL INVESTMENTS: NONE**

**01**

### ESTABLISH SERVICE-INTEGRATION TO IMPROVE ACCESS TO TEAM-BASED CARE FOR EAST TORONTO COMMUNITIES WITH COMPLEX NEEDS

- Establish clinical leadership roles
- Establish principles for collaboration and criteria for collaborative projects
- Undertake and evaluate pilot initiatives
- Participate in system planning including local health care initiatives with a focus on health equity, health promotion, community governance, team-based care
- Enhance coordination to ensure aligned service delivery
- Engage partners and funders on service development

### EXPLORE SERVICE INTEGRATION PARTNERSHIPS WITH COMMUNITY MENTAL HEALTH AND OTHER HEALTH & SOCIAL SERVICE PROVIDERS

- Determine information and referral processes to enhance service for priority communities
- Determine process to ensure network and referral methods do not reduce access for populations each member center serves

**02**

**TIMING: SPRING 2019**

**ADDITIONAL INVESTMENTS: NONE**

**TIMING: FALL 2019**

**ADDITIONAL INVESTMENTS: REQUIRED**

**03**

### NETWORK DEVELOPS COMMON INFORMATION AND REFERRAL AS A PATHWAY TO SERVICES

- Community mental health services partnerships could include both ongoing community support and crisis intervention services.
- Other partners could include pharmacies, public health, other health care providers
- Initiatives could include: influenza immunization, pediatric clinics, chronic care, digital health initiatives, healthy child screening, mental health & harm reduction, other brokering of service contracts with various funders

**THE NETWORK IMPROVES ILLNESS PREVENTION, CHRONIC DISEASE MANAGEMENT, AND ED AVOIDANCE FOR PEOPLE WITH COMPLEX NEEDS**

**04**

### THE NETWORK SUPPORTS THESE PROCESS GOALS OF THE EAST TORONTO HEALTH PARTNERSHIP NETWORK:

- Every person will have access to primary care and inter-professional care when they need it
- Everyone will know how to access and navigate health care in the East
- Every health care provider will be connected as part of one system of care especially primary care

# Our CHC Partners also envision building capacity that supports a East Toronto Primary Care Network for integrated service delivery

## WITH INVESTMENTS, NETWORK TAKES ON ACCOUNTABILITY FOR TEAM-BASED CARE FOR PEOPLE WITH COMPLEX NEEDS

	PEOPLE CURRENTLY SERVED BY CHCs	PEOPLE CURRENTLY SERVED BY FHTs	PEOPLE CURRENTLY SERVED BY ANOTHER MODEL OF CARE	UNATTACHED PEOPLE
<p><b>CHC SERVICE HIGH PRIORITY</b></p> <p><b>CHC SERVICE LOW PRIORITY</b></p> <p><b>NOT A CHC SERVICE PRIORITY</b></p>				
<p><b>PEOPLE REQUIRING TEAM BASED CARE (COMPLEX NEEDS ~80K)</b></p>	<p>~ 20K PEOPLE</p> <p>CONTINUE TO SERVE FOR PRIMARY CARE</p>	<p>~ 20K PEOPLE</p> <p>CONNECT TO PRIMARY CARE NETWORK</p>	<p>~ 40K PEOPLE</p> <p>CHCs BEGIN TO SERVE WITH TEAM-BASED CARE</p>	<p>~ 3K PEOPLE</p> <p>CHCs BEGIN TO SERVE FOR PRIMARY CARE</p>
<p><b>OTHER PEOPLE (~190K)</b></p>	<p>~ 5K PEOPLE</p> <p>OVER TIME MINIMIZE</p>	<p>~ 5K PEOPLE</p> <p>WITH CARE COORDINATORS COULD SUPPORT</p>	<p>~ 155K PEOPLE</p> <p>EXISTING PRIMARY CARE CONTINUES</p>	<p>~ 11K PEOPLE</p> <p>WITH CARE COORDINATORS COULD SUPPORT</p>

## NETWORK MEMBER SENIOR MANAGEMENT HAVE JOINT ACCOUNTABILITY & COLLABORATIVELY OVERSEE PROJECTS

### COMPLEX CLIENTS SERVED BY CHCs

- CHCs continue to serve for primary care
- Network pools current funding and other investment resources for health care providers (e.g., chiropody, groups, psychotherapy) to minimize gaps in access

### COMPLEX CLIENTS SERVED BY FHTs

- CHCs invite FHTs and other clinicians to join Network
- Network works with funders and partners to enhance team based care

### COMPLEX CLIENTS SERVED BY MDs / OTHER MODELS OF CARE

- CHCs begin to serve with team-based care to supplement services already being provided
- With investments, integrate different methods of embedding health care providers with primary care service providers (e.g. HATP, SCOPE, SPIN, Diabetes Care Connect, Regional Chronic Disease SMP as models)
- With investments, CHCs further extend hours of service to additional after hours/weekends

### COMPLEX CLIENTS UNATTACHED

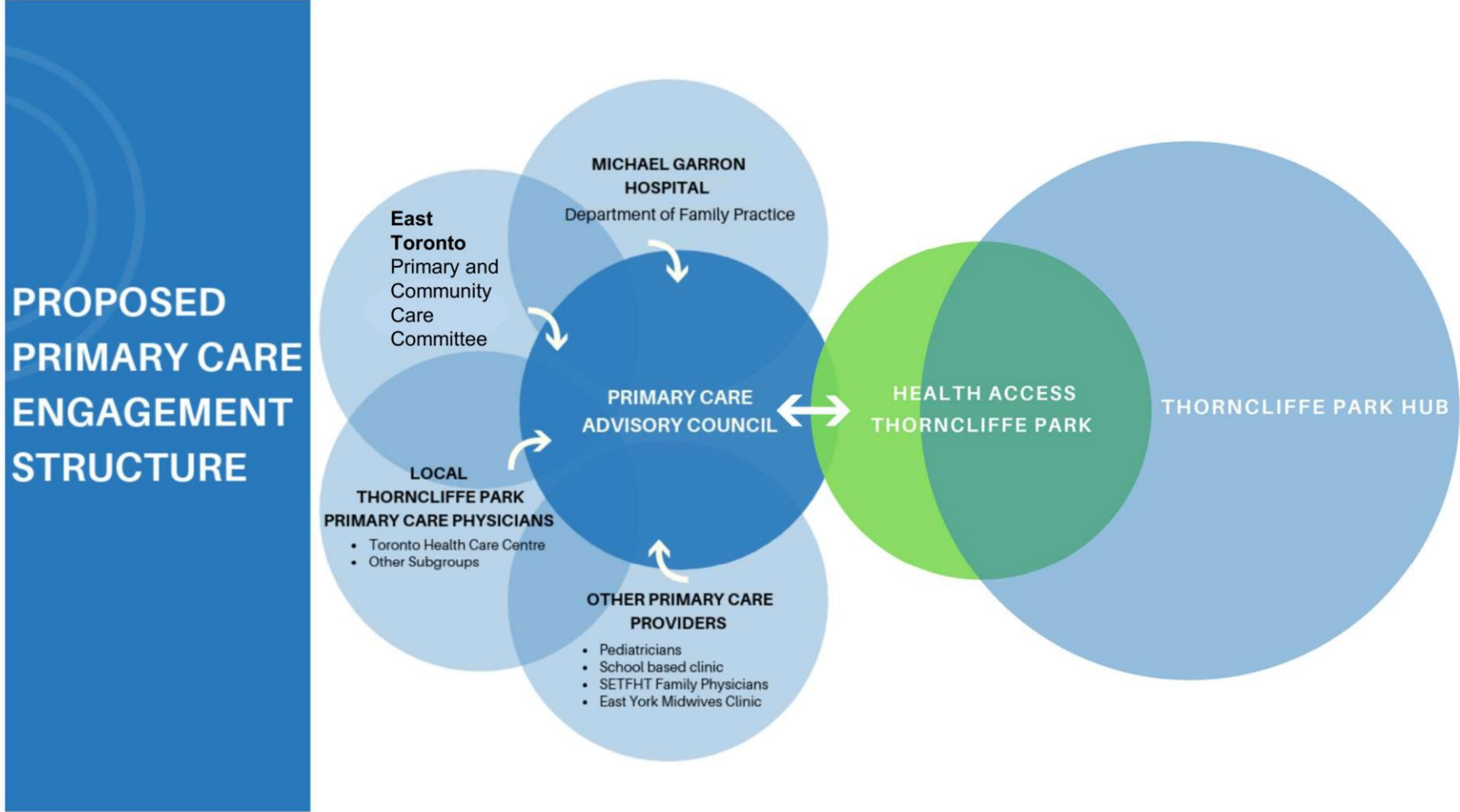
- CHCs begin to serve for primary care
- Network prioritizes these people for ongoing primary care through central access points

### OTHER PEOPLE SERVED BY CHCs

- Over time, CHCs minimize service delivery with enhanced focus on people with complex needs



# At a neighbourhood level, Partners in Thorncliffe Park established a local approach to Primary Care Governance and Engagement



# As we scale, EHP commits to building on these early efforts and current assets, deepening the integrated service offerings at maturity



## Enhancing Primary and Community-Based Care

Establish our offer to **260 primary care partners**: continue to expand SCOPE and SPIN

Scale successful **Neighbourhood Care Team** model to all East Toronto neighbourhoods



## Meeting Diverse Needs

Expand **language services** including **Active Offer** for French Language Services (leveraging existing MOUs)

Deepen our partnership with our **Indigenous community and partners** (building upon current services and partnerships within MGH and South Riverdale CHC)



## Developing Innovative Solutions with People

Support purpose-built **housing** for vulnerable communities (177 Gerrard)

Reimagine long-term care in East Toronto, recognizing the local expertise of Baycrest and WoodGreen as leaders in enhanced Adult Day Programming (**virtual long-term care**)

# To support our implementation of these Future Models, EHP Anchor Partners signed an “Intention to Commit” in Fall 2018

*(Excerpt from 3 page document signed by all Anchor Partners)*

East Leadership Table Working Agreement  
Intention to Commit to an East Toronto Health Partnership

I, Sarah Downey, on behalf of Toronto East Health Network in consideration of the Toronto Central LHIN (“LHIN”) agreeing to *engage me as a member of the East Toronto Health Partnership Executive Leadership Table* (the “Table”), agree as follows:

## **I. Organizational Obligations:**

1. I acknowledge that the Vision is to develop an East Toronto Health Partnership / Network (“the Partnership”) for East Toronto, which includes shared accountability across providers that receive funding from the Toronto Central LHIN.
2. I acknowledge that our established Goals are as follows:
  - a. Every person will have access to primary care and inter-professional care when they need it
    - i. There will be one number to call when they need to be connected to health care services
    - ii. Residents will have access to care that meets their needs (e.g., in their own language, using technology in appropriate ways, etc.)
    - iii. Residents will be supported to learn about the health care system and what is available for meeting their needs
  - b. Everyone will know how to access and navigate health care in the East
    - i. All residents in East Toronto will have the opportunity to be rostered to a primary care provider
    - ii. All residents will have choice and flexibility in where they can receive primary care
    - iii. Primary care will be available when people need it and urgent care will be offered

## **ETHP looks forward to this opportunity to innovate, and with the Province's support, will accelerate our efforts to integrate care**

- The East Toronto Health Partners are ready for change, and our long history of collaboration creates the 'momentum of trust' necessary for change:
  - ✓ Trusted relationships and partnerships, with distributed leadership
  - ✓ A collective focus on adapting to changing local needs in East Toronto for >40 years
  - ✓ A comprehensive basket of health and social services, tailored to our local communities
  - ✓ Over 1.5 years on joint venture planning and governance alignment for the East Toronto Health Partnership model
- To advance the Partnership, we will finalize our joint venture to accelerate integration – enabling partners to pool assets, and human and financial resources

**With governance and leadership onboard, we are keen to partner with government to implement an Ontario Health Team for East Toronto**

**Thank you from the  
East Toronto Health Partners**