NORTH TORONTO ONTARIO HEALTH TEAM
FULL APPLICATION

Wednesday, October 9, 2019.

Dear Deputy Premier and Minister Elliott:

RE: North Toronto Ontario Health Team Full Application

We are pleased to submit our full application to become an Ontario Health Team.

The North Toronto Ontario Health Team represents the full continuum of care, and brings a commitment to expand our partnership to serve everyone living in our community, and seeking care in North Toronto. Since the formation of our partnership in January 2019, our partners have demonstrated a strong sense of collaboration, and are ready to embark on this transformational journey together. We are:

- Baycrest Hospital
- Client, patient, family, caregiver and community representation
- Home and Community Care
- LOFT Community Services (LOFT)
- Primary care partners
- SE Health (member of the SE family of companies)
- SPRINT Senior Care (SPRINT)
- Sunnybrook Health Sciences Centre (Sunnybrook)
- Unison Health and Community Services (Unison)
- VHA Home HealthCare (VHA)
- Vibrant Healthcare Alliance (Vibrant Health)

To fulfill the vision of Ontario Health Teams, we have built our team based on the principles of inclusivity and transparency and are engaging with all relevant stakeholders, including patients and community representatives, and primary care providers, to co-design an integrated health care system. We are excited to submit our full application to becoming an Ontario Health Team, and request your consideration as an early leader in working with you as one of the province's first Ontario Health Teams.

Sincerely,

Baycrest Hospital

Client, patient, family, caregiver and community representation

Home and Community Care

LOFT Community Services

Primary care partners from the North Toronto area

SE Health (member of the SE family of companies)

SPRINT Senior Care

Sunnybrook Health Sciences Centre

Unison Health and Community Services

VHA Home HealthCare

Vibrant Healthcare Alliance

cc. Mrs. Helen Angus, Deputy Minister, Ministry of Health

Dr. Rueben Devlin, Special Advisor, Ministry of Health

Mr. Phil Graham, Executive Lead Ontario Health Teams, Ministry of Health

Ontario Health Teams
Full Application Form

Introduction

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

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

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

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

This application form consists of seven sections and two appendices:

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

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

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

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

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

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

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

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

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

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

Information to Support the Application Completion

Strengthening the health care system through a transformational initiative of this size will take time, but at maturity, Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a defined population of Ontario residents, and will be accountable for the health outcomes and health care costs of that population. Identifying the population for which an Ontario Health Team is responsible requires residents to be **attributed** to care providers and the method for doing so is based on analytics conducted by ICES. ICES has identified naturally occurring networks of residents and providers in Ontario based on an analysis of existing patient flow patterns. These networks reflect and respect the health care-seeking-behaviour of residents and describe the linkages among residents, physicians, and hospitals. An Ontario Health Team does not have to take any action for residents to be attributed to their Team. As per the ICES methodology:[1]

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

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

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

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

Participation in Central Program Evaluation

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

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

Ontario Health Teams
Full Application Form

Additional Notes

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

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

Ontario Health Teams
Full Application Form

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Kunal Patel
	Title: Project Director
	Organization: Sunnybrook Health Sciences Centre
	Email: northtorontooht@sunnybrook.ca
	Phone: 647-539-9452
Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Kunal Patel
	Title: Project Director
	Organization: Sunnybrook Health Sciences Centre
	Email: northtorontooht@sunnybrook.ca
	Phone: 647-539-9452

1. About Your Population

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

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

1.1. Who will you be accountable for at maturity?

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

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

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

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

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

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

Maximum word count: 1000

Our Population

After careful deliberation and review of our dataset, we would rate the degree of alignment between the population and service area we originally proposed and our attributed population as high.

Specifically, the attribution model attaches 25,000 (10%) fewer people than the geography-based estimate in our self-assessment (~178,000 in attribution model and ~204,000 in self-assessment). We believe that these numbers are similar enough in scale to give us the confidence that our service capacity can meet the demands of our attributed population.

In addition, based on the address of the attributed primary care enrollment models (PEMs) provided, the network attribution model shifts our expected service area more to the south than originally proposed and includes primary care partners we had not originally anticipated. We are confident the community partners in our OHT have the capacity and reach to manage this demand. This shift will enable us to have a more targeted approach to primary care, and to organize care networks that are more responsive to our communities healthcare needs, including chronic disease.

Overall, we expect these differences will not appreciably affect the population health profile we were originally considering. We intend to make ongoing adjustments to our planning/collaborations to ensure we can fully exploit the benefits the attribution model provides.

Our Approach to Population Health Management

The North Toronto OHT (NT OHT) has reviewed the experiences of other jurisdictions that have implemented a population health approach, and have engaged with the Rapid Improvement Support and Exchange (RISE) resources. We have also considered learnings from Accountable Care Organizations (ACOs) and the ACO population health-based approach to health care delivery.

Based on the learnings of Kaiser Permanente, our Executive Leadership Team (ELT) has adopted a population health management approach modeled on the Kaiser Permanente Pyramid.

This population segmentation framework has been used successfully as a means to structure an integrated, value-based approach to health care delivery, and provides the flexibility to offer different models of integrated care to different segments of the attributed population, depending on the needs of the population segment.

We are using this model as a macro-level risk segmentation framework to understand and plan for services for our attributed population. Using per capita health costs by Health Population Group (HPG) as a proxy for health risk, we stratified our population using the Kaiser pyramid. (see Addendum 1)

1) Patients with High Risk Needs: have at least one complex illness, multiple co-morbidities, physical care needs and psychosocial barriers

2) Patients with Rising Risk Needs: have conditions that are not under control, and left unmanaged, will become high risk patients

3) Patients with Low Risk Needs: the segment of population that is healthy today

When real-time person-level data becomes available, we will be able to more directly determine our population risk segments while considering age and specific location of the residents, and will be able to more accurately project the rate at which we can expect to improve outcomes.

In the interim, based on analyses conducted by ICES, we have concluded the following about our risk segments:

- high risk: 7.4% of population; $368M of total costs
- rising risk: 17.3% of population; $121M of total costs
- low risk: 75.3% of population; $93M of total costs

We believe no single model of integrated care meets the needs of an entire population. By segmenting the population into different risk groups, we can design different models of integrated services for the different population segments. Based on need, service planning can then be conducted more holistically rather than based on the traditional siloed care of individual healthcare providers.

The segmentation framework can be further focused to structure the team's planning for Year 1 (frail seniors – see question 1.2) and also examined broadly to structure the team's planning at maturity (macro-level segmentation of the entire population).

We foresee three opportunities to transform our shared current competencies into the required competencies of population health managers:

1. Planning targeted interventions: When real-time person-level data is available on our attributed population, we can plan pro-active interventions for individuals within each segment. In the interim, we have been able to use proxies to start to plan care.

2. Organization of Primary Care: The attribution model is based on PEMs and will help us open and shape dialogue with targeted groups. We envision governance structures built and aligned with our attributed population segments to reflect the varying models of primary care in our OHT (FHO, FHT, FHG, Solo, CHCs, etc.). As our OHT matures, we expect to be able to re-shuffle and align referral networks and membership in the OHT.

3. Better forecasting of demand and capacity: Our attributed population is expected to experience significant growth in the future. We believe this lens will enable us to better plan our service delivery. While it is unclear what the impact of future population growth will be on our segmentation, we anticipate higher volume in the rising risk and high-risk population segments, as we know the population in North Toronto is expected to grow and seniors are expected to be the fastest growing demographic. We look forward to the opportunity to connect the newly attributed population to our PEM network.

Our Challenges

The attributed model does pose some unique challenges for OHTs based in large urban centres that will need close collaboration with the MoH and other OHTs to develop sector-leading practices to enable OHTs to thrive:

1) Overlap of providers across OHTs: the concentration of providers in Toronto and the GTA requires close collaboration to reduce redundancy and duplication of services

2) Patient choice brings a high degree of mobility across OHTs: patients commute to Toronto and seek care based on proximity to their place of employment. Patients also change their places of employment/residence while retaining previously established health-care relationships, driving the need for cross-OHT service relationships and forcing us to think innovatively and beyond our traditional geographic catchment areas

As stewards of population health, we accept accountability for health outcomes and managing healthcare costs of our attributed population.

1.2. Who will you focus on in Year 1?

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

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

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

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

Maximum word count: 1000

In Year 1, the NT OHT will focus our efforts on improving access and ensuring seamless navigation and coordination of care for frail seniors. Our Executive Leadership Team (ELT), including primary care physicians, hospitals and community-based providers, agree that frail seniors are the population that would benefit most from integrated and collaborative care. More specifically, given the opportunity to re-organize care networks to adapt to an aging society, we selected frail seniors as our Year 1 target population as they:

- Represent a large proportion of the NT OHT's attributed population: Seniors aged 65 years of age and older account for 19.6% or 34,878 individuals of the population attributed to our OHT (compared to 17.6% in Ontario) and is expected to have continued growth;

- Act as caregivers for other seniors: Many seniors within our population are caregivers to their spouse or family members. They require caregiver supports and resources to continue to care for their loved ones at home;

- Are the fastest growing population: Seniors 65 years of age and older represent the fastest growing population, with a growth rate of 12% between 2011 and 2016 compared to the overall population growth rate of 2% for the same geography; and,

- Experience high admission rates: 56% of all admitted patients were 65 years of age and older at Sunnybrook (2018-2019).

By focusing on this population, we can demonstrate a meaningful impact as measured by the quadruple aim on a significant proportion of our attributed population. As described in question 1.1, we have leveraged the Kaiser Permanente Pyramid for our fully attributed population of 178,000. We have now built a similar segmentation model specifically designed to meet the needs of our Year 1 target population to deliver specific services according to the needs of each population segment.

The three risk categories are as follows:

1) Seniors with High Risk Needs:
- These are individuals with at least one complex illness, may have responsive behaviours, mental health and addiction challenges and who have typically had at least one acute episode and they need support through the transitions in the health care system. These seniors are at significant risk of further deteriorating and require comprehensive, coordinated treatment plans and proactive management of health conditions to improve health outcomes.

2) Seniors with Rising Risk Needs:
- These are individuals with chronic conditions not under control, and if left unmanaged will become high risk individuals. These individuals require inter-professional and primary care, enhanced caregiver supports and access to community health services to support disease management and independence.

3) Seniors with Low Risk Needs:
- These individuals are deemed healthy or infrequent users of the health care system. These individuals will benefit from improved outreach to health literacy resources and health and wellness and prevention activities, and easy entry into the healthcare system when they need care to facilitate better self-management and maintain a healthy life.

While we await record level data, we have embarked on an analysis of each risk segment of our Year 1 population using Intellihealth HPG data as a proxy for health risk in our attributed population. Specifically, we have mapped seniors 65 and over to high, rising and low risk population segments based on relative costs per HPG and using the age breakdown available in Toronto to focus on seniors 65 and over. This led to the following breakdown of each segment: (see Addendum 2)

- 25% of seniors 65 and over are identified as high risk;
- 28% of seniors 65 and over are identified as rising risk; and,
- 47% of seniors 65 and over are identified as low risk.

We then narrowed our Year 1 focus from the ~34,000 seniors attributed to our OHT to a smaller number and distributed across the three risk segments, based on the following two factors:

1) Impact: ability to improve health outcomes in a short time period

2) Ability to serve: capacity based modeling to ensure we can serve our Year 1 population successfully, adopting a population health management approach

Based on these two factors, and through extensive discussions at our Executive Leadership Team and with our collaborators, we have determined that our ideal Year 1 population is 10,000 seniors. This approach will enable us to identify individuals who are at risk of 'climbing up' the pyramid (i.e. individuals in the lower and rising risk categories that are most in need of intervention) to prevent escalation and hospital admission, and enable us to care for individuals already in high and rising risk categories who may 'step down' the pyramid through improved integrated care.

Based on the data received for our attributed population, and using cost as a proxy for health risk, we identified two HPGs in our high risk group that require specific attention: dementia and palliative care.

Since age is the greatest risk factor for dementia and end-of-life care, we are affirmed in our decision to make seniors our focus in Year 1.

Today, these conditions account for a significant portion of health care costs, with dementia costing approximately $25,635 per person per year, and palliative care costing approximately $62,133 per person per year.

We anticipate that of the 2,500 seniors identified as high risk, over 500 individuals will require dementia-related care and supports, and a similar number of individuals will require end of life care.

By applying a population health lens, we will be well positioned to plan targeted and integrated care interventions, enhance primary care, and better forecast demand and capacity to meet the needs of this unique population.
Additionally, we will embed an equity focus to ensure the inclusion of marginalized subgroups, and that other socioeconomic factors, such as seniors who live alone and/or face economic disparities, are considered throughout care design and delivery (see question 1.3).

1.3. Are there specific equity considerations within your population?

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

Maximum word count: 1000

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

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

Our partnership is committed to delivering culturally appropriate and safe care. Partners within the NT OHT have a long-standing history of providing barrier-free access to services to a diverse group of communities, residents, and individuals.

Our Year 1 population is focused on seniors who may be experiencing chronic conditions in addition to age-related frailty. This group is already, by definition, vulnerable. Members of this population may be at risk for poor health outcomes as a result of lower income status, language barriers, and many other socio-demographic factors.

Senior Adults in the NT Sub-Region

In 2016, 16.0% of the population within the North Toronto sub-region was 65 years of age or older. This represents the highest proportion of seniors among the sub-regions located within the Toronto Central LHIN (TC LHIN). Moreover, more than half of the neighbourhoods within the North-Toronto sub-region had a higher than average proportion of seniors in their neighbourhoods compared to other sub-regions within the TC LHIN. For example, the Yonge St. Clair neighborhood had the highest proportion of seniors (29.9%) amongst all North Toronto sub-region neighbourhoods.

Single, unattached seniors may have higher needs than those living with others, as they do not have caregiver(s) living with them to provide immediate assistance with activities of daily living and physical and mental health supports. Within the North Toronto sub-region, over one third (36%) of adults aged 65 and over reported living alone (Ontario Community Health Profiles Partnership, 2016). Furthermore, seniors living alone are at most risk of economic insecurity. Based on data from the Ministry of Health provided to support the Integrated Health Service Plan (2018), the TC LHIN had the highest proportion of seniors living in poverty, with approximately 14% of adults aged 65 years and older who reported living below the low-income measure

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

after tax (LIM-AT). Income and wealth inequities affect seniors by creating housing insecurity, limiting access to home and community care, making prescription drugs less affordable, and lead to poor nutrition and other unmet health care needs (e.g. Mental Health and Addictions, and responsive behaviours).

Additionally, using the TC LHIN sub-region data, the North Toronto sub-region has identified other vulnerable and marginalized populations that, at maturity, will require the OHT to engage in specific accommodation throughout care design and delivery to improve overall health status.

Indigenous
The Indigenous population of the North Toronto sub-region is anticipated to be approximately 3,700 people (Our Health Counts Toronto Indigenous Population Estimates). Assuming the age distribution of Indigenous peoples is the same as the North Toronto sub-region, approximately 16% or 592 individuals are 65 years old and older. Within Toronto, 87% of Indigenous adults were below the before tax Low-Income-Cut-Off (LICO); and over one in four Indigenous individuals have experienced discrimination as a result of emotional or mental health problems, of which 58% reported that this discrimination has delayed or prevented them from receiving care.

Francophones
The City of Toronto is one of the 26 designated French Language Services (FLS) regions in Ontario (Ministry of Francophone Affairs). As such, our team has included this region's Francophone population into our equity considerations. There are approximately 5,450 Francophones who live within the North Toronto sub-region. In regards to this population's age distribution, only 20% of the Francophone population is under the age of 19, which is lower than the general population in North Toronto (22.0%). In contrast, 19.5% are seniors (65 years and older), which is higher than the general population in North Toronto (15.9%) (Health Analytics Branch, LHIN and Sub-Region Census Profile, 2016). This aging population requires specific services, delivered in French, to reduce confusion in their care and promote understanding of their health needs.

New Immigrants
The North Toronto sub-region has the lowest proportion of immigrants among the sub-regions; the total population in private households that were recent immigrants (2011-2016) was 5.7% (11,465) compared to the TC LHIN at 5.5% (66,130) and the City of Toronto at 7.0% (187,950). The North Toronto sub-region and TC LHIN had a lower proportion of refugees and immigrants sponsored by family compared to other LHINs, with the majority migrating as a result of economic opportunities (e.g. economic migrants). The top three non-official languages most spoken at home in the North Toronto sub-region were: Tagalog, Spanish and Persian.

Uninsured
Uninsured residents are a vulnerable population that is not well captured in traditional population and health databases. They include those in the three month OHIP waiting period, temporary visa holders, and refugees. It is estimated that 35,000–90,000 uninsured individuals reside in the GTA, with the majority having an income below $15,000.

Housing
The NT sub-region has 28 Toronto Community Housing developments, representing 138 buildings with a total of 1,988 units. There are no shelters for homeless individuals within the NT sub-region. Additionally, there are nine retirement homes with a total resident capacity of 1,195 and five LTC homes with a total of 951 beds. In 2018, there were 775 individuals awaiting a LTC bed in the NT sub-region.

LGBTQ Seniors

LGBTQ individuals face higher rates of mental health and addictions, including but not limited to depression, anxiety, self-harm, substance abuse, and higher rates of violence and discrimination. SPRINT Senior Care has established itself as a leader in older LGBT inclusivity within the community support service sector. Specifically, SPRINT Senior Care has published a toolkit for community agencies and other organizations to use as a guide to providing care and services to older LGBT adults: Equity Begins at Home: A Guide to Creating LGBT Inclusive Community Support Services for Older Adults.

Elderly well-patients Taking Care of their Significant Others
This population is of importance given our year 1 focus on frail seniors, and the need to understand caregivers that support this population. We will examine this populatoin in further detail as we move forward.

2. About Your Team

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

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

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

Note:

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

2.1.1. Indicate primary care physician or physician group members

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

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

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

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

physician(s and their associated incorporation name).					
See supplementary Excel spreadsheet					

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

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

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

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

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

Max word count: 500

Our partnership includes primary care representatives, individuals/patients/family advisors, 1 mental health and addiction service provider, 2 service provider organizations (SPOs), 1 community support services organization and 2 hospitals (including one acute). This focused collaboration began prior to the announcement of Ontario Health Teams (OHT) and was used to explore how local health services could be better coordinated to improve health outcomes, patient experience, and value.

As OHTs were announced by the Government, we recognized how this directly related to existing sub-region priorities and re-deployed our resources and efforts to

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

ensure alignment and continuity. We built our team based on the principles of inclusivity and transparency both within the participant membership and with our partners in our communities. This meant a collaborative / participatory model and on a voluntary basis recognizing this is a system approach that is committed to bringing multiple partners to the table to test new incentives and measures of accountability that focus on the quadruple aim. We have very deliberately ensured that our membership includes all of the Acute, Community Support Service (CSS), and Community Health Centres (CHC) organizations that are located in the North Toronto sub-region and the main providers of Mental Health and Addiction services, and Home Care agencies, as well as primary care/family physicians to ensure service coverage for our population.

At this point in time, we should note that we do not have representation from a Long Term Care organization or specialists (outside our hospital members). However, we have plans to actively engage with these providers in our region to understand the potential interest there may be, especially given our Year 1 focus on frail seniors.

Additionally, we note that primary care is foundational for the future success of our work, and members have over a decade of experience co-creating care models with primary care. We are formalizing representation at our leadership table and similarly looking to expand our Primary Care collaboration via engagement events through the North Toronto Sub-Region and Primary and Community Care Council (PCCC) efforts. We believe our membership reflects our planned service population very well in Year 1 specifically, but also at maturity, especially as we plan to grow our membership base to enhance service capacity. For example: all of our members have a special focus on improving the care for seniors outlined in their strategic plans, or existing program delivery.

Strategically, we hold a significant advantage in having fewer service providers in the NT area (2 hospitals, 1 CSS, 2 CHCs, 1 FHT) which makes engagement simpler and less burdensome in building governance and partnership agreements, enabling quicker decision making, and being much more nimble and flexible in our delivery of care. In summary, our collaboration is both deep and wide, and is primarily the result of pre-existing work on the multitude of grassroots and clinician-led initiatives we have established from the bottom-up.

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

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

			member provides services in multiple regions)
See supplementary Excel spreadsheet			

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

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

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

Identify which members of your team have long-standing working relationships, and which relationships are more recent. Also identify whether there are any members of the team who have ***never*** previously worked with any other members of the team on initiatives related to integrated care, shared accountability, value-based health care, or improvement at the population health level.

Max word count: 2000 The North Toronto OHT (NT OHT) was formed in January 2019 to renew our commitment to accelerating sustainable and transformational change in health care within North Toronto. Our Executive Leadership Team (ELT) has committed to a common vision, guiding principles, and goals for success as reflected in a “Statement of Intent” co-signed April 2019. We have made significant progress, already identifying areas of work that will form the foundation of our OHT. These early steps will allow us to improve access to health and social services and bring us together as a single care system for the people we serve. Examining our historical relationships through the lens of integrated care, shared accountability, and value-based health care and population health, we have categorized our work into three areas: 1) No relationship: where there is no historic or current relationship between team members

2) Transactional: where there are simple hand-offs of information or services with lower trust and surface-level communication;

3) Integrated: where there is close coordination of planning, goals and decision-making; may include shared funding arrangements; deeper communication, higher trust and more time invested

At a high level, our relationships mainly reside at the “Integrated” level. All organizations that are part of our OHT membership have worked with at least one other member of our OHT team, which demonstrates the strong foundation and baseline we are privileged to be starting from.

Below are the four most prominent examples of our work together:

Example 1: North Toronto Advisory Table (formerly Health Links)
This collaboration has been in place since 2012, actively engaging 20+ health service providers and a wide range of community social services and volunteer organizations that reflect our diverse local populations such as community settlement programs and citizen representation. Notably, this collaboration includes every member of our OHT. The work of this collaboration brings together leadership from across a variety of sectors, representing populations and geographies in the sub-region, to provide a broad perspective and advance ideas through organizational support and leadership to advance the health and social goals of the region. The work of the North Toronto Advisory Table supports regional planning and joint initiatives, and identifies how providers can collaborate to address health gaps and improve patient experience and outcomes. The work is jointly chaired by Dr. Yoel Abells (Primary Care Lead), and Stacy Landau (CEO, SPRINT Senior Care).

Specifically, the North Toronto Advisory Table’s work includes:
- Identifying current and emerging issues using a population lens
- Providing strategic perspective on current and emerging issues
- Enabling action, through strategic, cross-sectorial planning sessions, on the various initiatives underway
- Encouraging and facilitating collaborative problem solving and approach
- Developing recommendations focused on the resolution of local system issues including creation of pathways for care that address the unmet needs of people in the Sub-Region and initiatives that help when there is no existing appropriate service to meet population care needs
- Supporting the advancement of Quality Improvement initiatives in the region
- Creating a framework to determine the initial priorities to be achieved in the first year

Example 2: North Toronto Primary and Community Care Committee (PCCC):
The North Toronto PCCC was formalized in 2016 (collaboration predates this) and works proactively with Primary Care to create a network that identifies population and primary care needs and responds by engaging health and social system partners to co-

develop innovative direct care service delivery models. The committee is co-chaired by our local primary care physicians Dr. Yoel Abells and Dr. Jocelyn Charles. This group meets monthly with primary care representation from the different models (i.e., FHT, FHO, FHG, and CHC) with the aim of creating a network responsive to population and primary care needs. The PCCC engages both in-person and through bi-monthly newsletters with 280+ primary care providers in and surrounding North Toronto. Many NT OHT members are involved, including Primary Care representatives, Toronto Central LHIN, Sunnybrook Health Sciences Centre, SPRINT Senior Care, Unison Health, LOFT Community Services, and Vibrant Healthcare Alliance. From a results perspective, the PCCC is the coordinating / advisory committee that guided the implementation of the initiatives related to SCOPE (Seamless Care Optimizing the Patient Experience), TIP (Telemedicine IMPACT Plus), and the IPCT (Inteprofessional Priamry Care Team). The PCCC is co-chaired by Dr. Yoel Abells, and Dr. Jocelyn Charles.

Example 3: Pine Villa
Pine Villa is a 68 bed facility funded by the Toronto Central LHIN (TC LHIN) to provide a short-term transitional care model (STTCM). It is located at 1035 Eglinton Avenue West, and is operated under the Home and Community Services Act as a transitional supportive housing reintegration unit (RIU) for patients discharged from TC LHIN hospitals that no longer need acute care services, but still require care and support in preparation for their final discharge destination. It was previously operated as a private retirement home by Revera Inc. However, due to a number of factors, it was closed. Since then, the property has been leased to Sunnybrook starting January 2018, and become the home for Pine Villa.

As many individuals are in need of a primary care provider during their transition, Sunnybrook teamed up with VHA Home HealthCare to create a unique in-house primary care model incorporating a VHA Nurse Practitioner who functions as Most Responsible Provider and two Sunnybrook consulting physicians. The provision of in-house primary care is a key strategy in preventing ED visits and hospital admissions.

The services provided at Pine Villa are an innovative model of service integration between the hospital and community service providers, purposefully designed as a collaboration between Sunnybrook, LOFT Community Services (LOFT) and SPRINT Senior Care (SPRINT) in which each organization plays a unique role. Specifically, LOFT (focused on mental health & addiction & behavioral support) and SPRINT (focused on senior care and dementia and Alzheimer's) provide front line care to individuals admitted to Pine Villa, with Personal Support Workers (PSW), Recreational Therapists (RT), Social Workers (SW) and Registered Practical Nurses (RPN) staffing; while Sunnybrook handles facility management and support services (e.g. food, housekeeping, security, etc.). Under this model, patients are discharged from the acute care hospital and sign a short-term service agreement with SPRINT or LOFT. A joint steering committee helps govern the care facility where all three parties convene monthly to discuss operations and quality of care.

Prior to the opening of Pine Villa, Sunnybrook was caring for an average of 86 Alternative Level of Care (ALC) patients each day (with peaks nearing 100 ALC patients), critically impacting its ability to provide acute care services. Pine Villa has helped provide a mechanism for the hospital to improve ALC patient flow.

Pine Villa patients gain the benefit of therapeutic support in a much more comfortable and home-like environment which has also had a positive impact on families and caregivers. This benefits the system by freeing up desperately needed acute beds for those who need them most. From February to June 2018, there were 109 referrals to Pine Villa, with 88 acceptances. The average time to referral has been approximately 4 days, thanks to a streamlined referral process. All 88 accepted individuals were designated ALC or at-risk of ALC and had an average MAPLe score of 3.3, with the majority of individuals falling on the higher end of the MAPLe spectrum. Turnover at Pine Villa has created rapid flow of individuals discharged since opening to an appropriate place of care – including home. This has translated to additional acute care capacity throughout the system.

Example 4: Neighbourhood Care Teams (NCT)
Recognizing the current challenges in health care, the Toronto Central LHIN set forth a call to action for innovation in care models in 10 priority neighbourhoods within the LHIN. This call to action was a challenge to innovate through a Neighbourhood Care Team approach. The goal of these NCTs is to provide integrated models of care, accountable to meeting the needs of people living within the urban neighbourhoods of the Toronto Central LHIN. This is a collaborative, integrated approach to care which brings new thinking and direction to the home and community sector. The model establishes strong linkages across the care continuum including primary care, hospitals, community support, paramedic services, housing services, mental health and home care. Most importantly, this model empowers patients and caregivers to be meaningful participants in their health and wellness journey.

Organizations vary by building site but involve all of our North Toronto OHT participants and many of our Collaborators including local primary care providers. A key component to the NCT model development was co-design with the patients. Resident town halls, hallway socialization, door to door engagement and surveys were just a few of the strategies used to get peoples' input on the model design. Of note, the team arranged for volunteer translators to ensure we could engage all residents representing eight dialects.

Currently this program is in a detailed planning phase. We are anticipating some key outcomes when the NCTs are rolled out, including:

- Integrated model of care that is accountable to meeting the needs of people living within a high-density urban neighbourhood

- Prevention of avoidable ER visits and enabler of early discharge from ALC

- An engaged and empowered community with a focus on person centred care, self-management and independence

The NCT model will be based on a hub and spoke approach, will leverage a collaborative central intake and assessment process and will be accessible 24/7.

We believe this rich and intricate provider network, which we have been building together over many years, is only the tip of the iceberg; we each have unique relationships with each other and with other external collaborative organizations to our OHT. The network we have created is the fundamental reason why we believe our NT OHT can be successful in growing capacity to drive meaningful change for our attributed patient population.

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

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

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

Max word count: 500

After reviewing the full data set provided by the MoH, we have noted that there are sixteen primary care patient enrollment models attached to our OHT (~133,000 people or 75% of our attributed population), and an additional (to be determined) number of FFS/solo providers (~44,000 people or 25% of our attributed population). Without further detail on the FFS/solo providers, we would rate the degree of alignment between our current OHT membership and the aforementioned provider networks between moderate and high.

Moderate: we understand that the network attribution model is challenging in urban centers due to proximity of health service providers. For example, in 9 of our 16 PEMS, patients may be better aligned with a different OHT. We look forward to the opportunity to work with the Ministry of Health, other OHTs, primary care providers and patients to understand the magnitude and impact of these potentially split alignments. Together we can learn how to balance data, relationships, local practicalities, and population growth to re-shuffle and align membership in the OHT and referral networks.

High: we have existing working relationships with almost 90% of the providers and our shared patients. Specifically, we can confirm that we have historical working relationships via our North Toronto Primary Care Sub-Region Team with 14 of the 16 PEMs. We would also note that two Community Health Centres (Vibrant and Unison) are on our OHT Executive Leadership Team, though (as we understand it) they are not used to attribute patients to the OHT model. Additionally, we would note that there is extensive data analysis that we've done with the TC LHIN on primary care models and this is consistent with our previous analysis and our self-assessment.

Our membership, as listed in question 2.1.1 and question 2.6.1 includes the most engaged primary care and specialist providers that are most proximal to the geographically-based attribution we assumed in our self-assessment. It is with these providers that we expect to have the largest impact on the quadruple aim in Year 1. Specifically, our most recent engagement meeting was on September 18, 2019 with many primary care physicians electing to learn more about co-designing integrated collaborative care with our OHT. We have plans to continue to engage with all attributed PEMs and solo/FFS providers and are conducting sensitivity analysis to elicit opportunities to update our team membership and collaborations. We are confident that through collaborative planning with primary care and other OHTs we can continuously update the attachment of primary care and patient attribution.

We would like to note that we have been attributed to City Medical FHG (based in Mississauga) which we have not had any connection with and would need to examine record level data to better understand any collaborative opportunities that may exist. Additionally, there are 5 practices in North Toronto currently not attributed to our OHT that have been, and continue to be, engaged by the Primary Care Working Group of our North Toronto OHT.

2.6. Who else will you collaborate with?

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

2.6.1. Collaborating Physicians

Name of Physician or Physician Group	Practice Model	Number of Physicians	Collaboration Objectives and Status of Collaboration

			Describe your team's collaboration objective (e.g., eventual partnership as part of team) and status (e.g., in discussion)
See supplementary Excel spreadsheet			

2.6.2. Other Collaborating Organizations

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

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

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

Max word count: 500

Our OHT is defining integrated care as the elimination of fragmentation in patient care across the care continuum. Comparing the RISE practice guide on integrated care to our collective skills and assets, we believe we are well positioned and have identified several critical success factors that, on implementation, will ensure we achieve the targeted number of Year 1 patients to receive integrated care:

1) A defined / attributed population under our shared responsibility which we are analysing to build our collective knowledge and understanding of health needs

2) A network of health care organizations / providers that includes all levels of care and provides and integrates both personal and public health services

3) Coordination mechanisms throughout the entire continuum of care that are centred on the patient / family / caregiver

4) An integrated information system that links network members to enable sharing of patient health information, including with the patient

Our approach to integrated care is based on segmenting our population and supplying different levels of integrated care based on patient needs (i.e. accountable care organization / population health management model). As such, the intensity of integrated care provided will be based on the specific needs of the patient and will be responsive towards both: (1) specific acute episodes of care; and (2) the need of ongoing management of chronic conditions over the course of our individuals' lives. The plan for our first year will be based on a patient-centered approach to care with an intimate clinician involvement in service planning and service delivery.

We understand that patient categorization within our risk pyramid is fluid and is dependent on multiple biological, psychological and social determinants of health. As such, our approach is a needs-based model, and not a provider-based model. It is one that will aim to match supply of resources with demand for services. For example, as a senior moves up the risk pyramid, they will require a higher degree of fully integrated care requiring additional resources and supports; patients may also move back down to rising risk and low risk categories as their health condition deescalates and improves, necessitating a lesser degree of care coordination across a number of providers. This model highlights the significant need for our OHT to act as "One Team" serving the patient, and their family and caregivers by matching our resources with their needs. We envision patients, caregivers, and families to be active participants in the management of their own health.

At this point in time, understanding our population's health conditions is critical to how we are re-designing care and will help inform the specific interventions that are required. We would like the opportunity to further validate utilization of specific services for our Year 1 population in order to better forecast demand and capacity requirements as we implement fully integrated care for our patients.

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

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

Service	**Proposed for Year 1** (Yes/No)	**Capacity in Year 1** (how many patients can your team currently serve?)	**Predicted Demand in Year 1** (of your Year 1 population, how many patients are predicted to need this service)	**Description** (Indicate which member(s) of your team will provide the service. If a proposed service offering differs from your team's existing service scope, please provide an explanation as to how you will resource the new service. If there is a gap between capacity and predicted demand, identify if you have a plan for closing the gap.)
See supplementary Excel spreadsheet				
Interprofessional				

team-based primary care				
Physician primary care				
Acute care – inpatient				
Acute care-. ambulatory				
Home care				*Please complete Appendix A.*
Community support services				
Mental health and addictions				
Long-term care homes				
Other residential care				
Hospital-based rehabilitation and complex care				
Community-based rehabilitation				
Short-term transitional care				
Palliative care (including hospice)				
Emergency health services (including paramedic)				
Laboratory and diagnostic services				
Midwifery services				
Health promotion and disease prevention				
Other social and community services (including municipal services)				
Other health services (please list)				

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

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

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

Max word count: 500

Our OHT will focus on integrating additional members and collaborators over the next several years across the entire continuum of care, including, but not limited to: LTC, Primary Care, Emergency Services, Specialists, and non-traditional members.

We recognize that our population is growing and our focus will shift as we evolve. As such we are building a governance framework that will recognize how new members/collaborators can be added without undue burden. We anticipate that there will be some fluidity to our membership over time as a result. We are committed to working towards a macro-level segmentation of our population to inform our decisions once we have record-level data available.

One critical element of our team membership focus is and will continue to be on primary care. This will include PEM models that are attributed to our OHT, but also solo practitioners, walk-in-clinics, and urgent care centres. We anticipate this to be a sizeable effort to coordinate, but will provide essential coverage for our attributed patient population.

We do anticipate facing challenges in meeting care needs for those attributed patients that live geographically outside of our catchment (e.g. CSS, Home Care). Contractual arrangements will likely need to be formalized with other OHTs to ensure service coverage. This will require the development of an inter-OHT billing/payment infrastructure (currently non-existent). A single unified approach across all OHTs would be ideal to leverage economies of scale prior to making significant investments.

Our immediate population focus beyond Year 1 will be three areas:

1. Deeper and broader expansion of our frail seniors population:

Beyond Year 1, we will continue to expand our frail senior population outside of the initial 10,000 target. This will be accomplished through re-designed programming and enhanced primary care collaboration and service integration.

2. Mental health and addictions (across the age-continuum):

This population is of high importance according to the data package provided to us by the Ministry as reflected in the number of individuals associated within these specific

Health Population Groups. We believe that this is an important consideration for our OHT and the impact it could have across our listed key performance metrics. Notably, we do not have an adult/senior Mental Health and Addictions community provider centralized in our geography and therefore we will be leveraging LOFT Community Services to act as a lead agency to identify and link patients to appropriate mental health and addictions providers (e.g. LOFT and Skylark have existing co-located projects). We do plan to expand collaboration with other mental health and addiction providers who we believe can play a significant role in enhancing our OHT's capacity for this type of service and that, with these relationships, the care model developed for our frail seniors population could be leveraged for this patient population.

3. Children & Youth care:
We believe this population is of utmost importance as they are critical to our population management approach, and represent a group that is often underserved/overlooked. We will approach this population segment through re-designed programming and enhanced pediatric care collaboration.

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

Max word count: 500

While not all primary care providers have joined the OHT as official members, primary care providers have been involved in North Toronto collaborative partnerships and initiatives over the past few years. The North Toronto Sub-Region Team and the Primary and Community Care Committee (PCCC) have been engaging providers and working with local partners from across the healthcare system to implement priority initiatives and improve care in identified areas.

The North Toronto Primary Care Sub-Region Team has regular engagement with all primary care providers in North Toronto. This work in primary care has successfully increased the capacity of many diverse primary care practices to be able to function in a fully integrated model and have demonstrated progress towards full integration as a result. The teams serving primary care providers in North Toronto (Sub-Region Primary Care Team, Seamless Care Optimizing the Patient Experience (SCOPE), and Interprofessional Primary Care Team) connect with practices on a regular basis to better understand and respond to the needs expressed by primary care. The primary care strategy work accomplished to date in North Toronto is well aligned with the Ontario government's Peoples Health Care Act 2019 and is an excellent foundation for further local primary care development and integration with the new Ontario Health Teams. Even though not all providers are official members, the majority of primary care providers attributed to the NT OHT are already involved in this integration work.

2.10. How did you develop your Full Application submission?

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

Also consider in your response:

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

Max word count: 1000

The NT OHT has been working in close collaboration with its members since prior to the announcement of the Ontario Health Teams (OHTs) by the Ontario Government in 2019. Throughout this journey, our member organizations, primary care provider participants, and patient, family member and caregiver representatives have established strong relationships, and have been actively engaged on a voluntary basis in the planning for this initiative throughout the preparation of the self-assessment, and now the full OHT application.

We have deliberately ensured that our membership/collaborations includes all of the Acute, Community Support Services, and Community Health Centre organizations, mental health and addiction services, home care agencies, primary care, and patient/family/caregiver representatives, to deliver on an inclusive process as we work toward co-designing our models of care as a potential OHT candidate. We also remain committed to extending team membership or close working relationships to other collaborators, such as long-term care and specialists, to inform the redesign of care services and ensure service integration for both our Year 1 population and our entire attributed population at maturity.

To complete our submission, we established a governance structure that consists of a project management working group and five working committees:

1. Executive Leadership Team (ELT)
2. Operations Committee
3. Communications Committee
4. Digital Health Committee
5. People Centered Care Council

The roles and responsibilities of each committee is determined by a Terms of Reference, and includes representation and leadership from all partner organizations within the North Toronto OHT. Additionally, our team sought input and expertise from primary care providers, physicians, individuals and organizations across the care continuum, as well as input from patients, family members and caregivers (see Addendum 3).

Leading up to the submission deadline, each working committee met regularly and worked collaboratively to understand the scope of the OHT application and its requirements, to reach consensus on the various elements of the OHT application, and to complete the drafting of the respective sections of the OHT application.

Particular and intentional effort was made to include the perspectives of the following NT OHT members as equal partners throughout this process:

Patients, Families, Caregivers & Community Members
All of our member organizations have a proven track record of meaningful patient, family and caregiver engagement and partnership activities (see question 5.3 for more information). We leveraged these strengths to engage a broad network of community groups across all organizations to inform strategic planning for, and co-design operational aspects of, our full OHT application.

Our People Centered Care Council, a group that includes representatives from each member organization's patient and family advisory committees, developed a set of guiding principles and minimum specifications that will act as the roadmap for how the NT OHT will engage patients, families, caregivers and community members in the planning and delivery of care moving forward (see question 3.8 for more information). Additionally, to ensure all work is patient-centered, members sought advice from citizen advisors on specific areas of work, for example Digital Health, and will continue to involve citizen advisors in the development of our processes and toolkits to ensure an inclusive patient-centered approach to re-designing care.

As we move forward, our OHT plans to create a Patient and Family Advisory Council to provide specific support to the Executive Leadership Team (ELT) and other OHT initiatives. This will produce tangible patient-centered changes across our OHT as services and care become more integrated.

Primary Care
From a primary care perspective, the plan for our OHT is to continue to build upon the significant work currently underway as part of the Primary Care Strategy developed over the past four years. Significant consultation has been conducted with our North Toronto primary care groups, led by a small group of North Toronto primary care clinical leaders, and input obtained from these groups was used to inform the development of the full OHT application.

Francophone
The NT OHT has been working in close collaboration with Reflet Salvéo, one of Ontario's six French Language Health Planning Entities, Fondation Hélène Tremblay Lavoie Foundation, as well as with the Francophone community residing in North Toronto. We have leveraged the results from multiple surveys conducted in the last few years by Reflet Salvéo to gauge the needs of the Francophone communities.

We have engaged with Les Centres d'Accueil Héritage on the Leadership Training on Active Offer to gain a greater understanding of the importance of French Language Health Services as part of the Ministry's transformational agenda, to provide a connected health care system centered on patients, families and caregivers, including Francophones.

As part of its mandate, Reflet Salvéo, in collaboration with the NT OHT, will be undertaking engagement sessions with the North Toronto's Francophone community to validate their needs at maturity. Our team remains committed to include the Francophone lens to enhance care coordination and navigation and promote Active Offer of French Language Services by collaborating with the two French Language Services designated health service providers: Les Centres d'Accueil Héritage and the Centre Francophone de Toronto.

Indigenous
Based on the Ontario First Nations Map of Indigenous communities, our attributed population does not include First Nation communities. Nonetheless, we remain steadfast in our commitment as an OHT and member organization to deliver culturally appropriate and safe care to all communities served, including Indigenous communities. Where appropriate, we will collaborate with and/or seek advice from Indigenous health service providers to deliver services.

3. How will you transform care?

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

By redesigning care for their patients, Ontario Health Teams are intended to improve patient and population health outcomes; patient, family, and caregiver experience; provider experience; and value. By working together as an integrated team, Ontario Health Teams are also expected to help improve performance on a number of important health system measures, including:

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

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

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

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

Max word count: 1000

Our OHT is seeking to provide a better care experience, improved health outcomes, and better value for our Year 1 and maturity populations. We intend to do this through targeted interventions designed to address the specific needs of our high, rising and low risk population segments, both for Year 1 and longer term.

We have identified our top three performance improvement opportunities and meaningful performance metrics for each of our population segments, both for Year 1 and longer term. We will engage the quadruple aim framework (outcomes, provider experience, patient experience, value / cost) to track our performance as we believe this is the most comprehensive approach to performance measurement. We will seek continuously to improve performance over time, targeting and tracking additional performance improvement opportunities.

Our OHT team members already employ many of the performance metrics listed above to measure our performance today. We will continue to capture and report these metrics, using the quadruple aim framework. We will engage in performance measurement with precision and purpose, without unduly burdening front line clinicians with unnecessary data capture / reporting obligations. A rigorous process has been followed to identify our top priority performance improvement opportunities and metrics that satisfy the following three priority criteria:

1) ability to impact change;

2) internal alignment; and

3) ability to measure;

Applying these criteria, we concluded we would focus in Year 1 on certain parts of the quadruple aim, and longer term on the full quadruple aim, prioritizing the following performance improvement opportunities and performance metrics for our population segments:

Seniors with High Risk Needs:
a) Increase # of seniors actively attached to a care coordinator: includes facilitating and coordinating acute care, community care, primary care, and specialist care, and will be critical in ensuring patients/families/caregivers are well cared for. (alignment with quadruple aim: patients/families/caregivers experience, provider experience, outcome, and value/cost)

b) Increase # of seniors attached to homebound primary care: homebound primary care enables our population to stay at home longer, in a setting where they are most comfortable (alignment with quadruple aim: patient experience, provider experience, outcome, and value/cost)

c) Achieve high patient feedback scores: obtaining patient feedback on patient experiences will be essential to tracking performance. We will use a simple set of questions focused on care coordination and integration. (alignment with quadruple aim: patient experience)

Seniors with Rising Risk Needs:
a) Reduce CTAS III – V Visits by seniors: Specific conditions are best managed outside of the ED. It is important to reduce avoidable ED visits to ensure more acute patients can be seen on a timely basis. Notably, our attributed population may visit EDs outside of the NT OHT region, which must be accounted for to show true impact. (alignment with quadruple aim: patient experience, provider experience, and value/cost)

b) Increase Physician attachment to Seamless Care Optimizing the Patient Experience (SCOPE) / Telemedicine Impact Plus (TIP) / Solo Practitioners in Need (SPIN): These programs are aimed at linking primary care with specialist supports and will help reduce avoidable ED visits/ admissions and tighten patient connections with community-based care. (alignment with quadruple aim: patient experience, provider experience, outcome, and value/cost)

c) Increase % of seniors that have access to interprofessional primary care team: having a greater number of seniors with access to interprofessional team-based primary care will be beneficial to the health outcomes of our patients and will help reduce avoidable ED visits/admissions. (alignment with quadruple aim: patient experience, provider experience, outcome, and value/cost)

Seniors with Low Risk Needs:
a) Increase % of seniors with virtual healthcare encounter in the last 12 months: Applying the Digital Playbook provided by the Ministry of Health, a virtual encounter could include: video visits, audio calls and electronic messaging. We anticipate achieving the provided 2 to 5% target of virtual health encounters through existing platforms, e.g. Ontario Telemedicine Network (OTN), and increasing this target through integrated platforms over time. This metric will be applied to track performance improvement for our Year 1 and attributed population. (alignment with quadruple aim: patient experience, and value/cost)

b) Increase % of seniors with access to digital health record: We are planning to leverage MyChart as our digital health record for patients to access and share their personal health information (PHI). We have a strong supporting base for this work, which we will enhance over time. We anticipate achieving the 10 to 15% target provided by the Ministry of Health for our Year 1 population. This metric will be applied to track performance improvement for our Year 1 and attributed population. (alignment with quadruple aim: patient experience, outcome, and value/cost)

See Addendum 4 for summary table.

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

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

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

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

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Our care re-design encompasses evidence-based approaches that will enable us to achieve our quadruple aim objectives and measure performance (see question 3.1).

Our OHT has an extensive list of our members' current programs that help us care for the patients we currently serve and lend themselves to integrating care and improving performance. Our intent is not to dismantle existing programs or create new programs in isolation. Instead, we plan to integrate and consolidate existing programs to break down silos, reduce redundancy, and improve efficiencies and outcomes, using the patient voice to guide decisions. As our redesign advances, we will scale-up resources in areas demonstrating success, and apply key learnings to other populations as appropriate. Our proposed approach involves two overarching phases.

Phase 1: Current State Assessment

Step A: Patient/Family/Caregiver voice: We will seek community and patient input and feedback to help us to refine our focus on concepts that matter most to our population.

Step B: Confirm inventory of current programs:
This work has been underway since our self-assessment and has been re-validated as part of this full application. Presently, we have a strong understanding of our current programs. A short-list of our most impactful programs is below:

1) High intensity care navigation: Sunnybrook's BetterCare tracking system identifies high-frequency, complex/frail ED users, with notification to their primary care providers or attachment to primary care where needed, and to facilitate implementation of comprehensive care plans that will succeed in meeting their care needs outside the hospital.

2) Enhanced Primary Interprofessional Care team ("EPIC"): The homebound primary care stream of EPIC supports dementia patients at home until the acute phase of death. EPIC offers 24/7 on-demand access to virtual nurse practitioners.

3) Regional Geriatric Program: Baycrest's and Sunnybrook's Geriatric Assessment Clinics and Day Hospitals offer geriatric services including: Geriatric Medicine and Psychiatry with rapid access to urgent assessment.

4) Mental Health and Addiction Supports for Seniors:

a) Crisis outreach: LOFT is one of three organizations working together to provide crisis support services to seniors in mental health or addictions crisis in Toronto. The crisis line worker will make an initial assessment of the risk and dispatch a crisis team to the senior's home.
b) Behavioural supports transition teams: provides a timely and knowledgeable response that enhances the healthcare services of seniors, families and caregivers, who live and cope with responsive behaviours, when they require it and wherever they live.

5) Team-based community care: We have designed and/or implemented several interdisciplinary care programs including: Neighborhood Teams, Integrated Community Care Teams (ICCT), Interprofessional Primary Care Teams (IPCT), House Calls, and CHC teams. Interdisciplinary models are critical to sustaining our rising risk population from escalating into high risk and supporting our high risk patients. As we grow our OHT membership, we envision linkages with other team-based community care as well.

a) Neighbourhood Care Teams: Two neighbourhoods have been identified to establish local, integrated, interdisciplinary models of care. These models are focused on integrating care so patients experience simple access to service when and where needed, navigation/coordination if unable to self-navigate/manage, and streamlined communications with health care providers.

b) EPIC: includes:

i) ICCT: Supports complex homebound seniors for comprehensive geriatric assessments and treatment plans.
ii) IPCT: A mobile, distributed, virtual-care-enabled collaboration of 12 nursing and allied health professions from 4 health-service providers embedded in 6 primary care offices in North-Toronto.

c) House Calls: Supports interdisciplinary primary care for homebound seniors to reduce hospitalization and avoidable ED visits.

d) CHCs: Vibrant and Unison provide integrated primary health care for frail and homebound seniors with the goal of keeping patients out of long-term care and emergency rooms as safely and as long as possible to live independently in the community.

6) Connected Primary Care: We aim to ensure a tighter connection between Primary Care, hospitals and community services, to reduce avoidable ED usage by expanding integrated, effective community-based care. Programs identified for expansion include: SCOPE, TIP, SPIN, and effective use of system navigators and

care coordinators.

a) Seamless Care Optimizing the Patient Experience (SCOPE) enables primary care access to specialist consults, creating a one-team approach to patient care.

b) Telemedicine IMPACT Plus (TIP) provides rapid access to a virtual team of professionals to enable proactive health and social care for patients with complex conditions and their caregivers.

c) Solo Practitioners In Need (SPIN) provides solo practitioners access to appropriate community-based services for their complex patients.

d) Care Coordinators work as part of an integrated team with community partners, home care service providers, and Primary Care, to coordinate care for complex patients and their caregivers.

7) Caregiver supports: Recognizing the vital role caregivers play, we will leverage SE Health's Elizz platform which provides 24/7 support via a chatbot and access to coaches for virtual support.

8) Health literacy, health promotion, and prevention programs

Step C: Segment assets / programs according to our population pyramid: Given our focus on population health management and risk segmentation, we plan to align our programs and services to our high, rising and low risk populations based on need. This will enable us to identify where we have service redundancy and under-served patients across organisations in a more pro-active and evidence-based way. Using available record level data, we will be able to map costs, HPGs and utilization patterns to specific programs to more accurately define the users of our services. This will help us form hypotheses around how we can better engineer our efforts to meet the needs of our patients.

Phase 2: Re-align, consolidate, and expand priority initiatives
This work will build the roadmap for our OHT's key initiatives. This is of critical importance as it will hone our thinking on initiatives we decide to pursue to achieve demonstrable impact on our Year 1 population. At a high level, we have several concepts under consideration which reflect the advanced thinking and alignment across our OHT. Below are examples of key initiatives underway:

(1) "Sunnybrook Connects" in the emergency department
Sunnybrook, SPRINT, and North Toronto home care agencies are engaged proactively in reducing avoidable admissions and ALC through enhanced community-based services. This work focuses on reducing hallway beds that are currently in the ED through efforts of an ED Community Transition Team that attaches patients to effective community-based care. The team is a home and community support hub with team members from community support and home care providers, positioned

within Sunnybrook's ED.

(2) Homebound Seniors:
We have 5 home-based primary care teams in North Toronto with a long history of providing comprehensive care in the home for frail seniors. These are: (#1) Sunnybrook Academic FHT, (#2) Vibrant Healthcare Alliance SHHP (Seniors Home Health Program), (#3) Don Mills FHT; (#4) Baycrest ICCT, and (#5) House Calls. These teams have helped enable North Toronto to have one of the highest rates of home-based primary care visits in Ontario (16.6 per 1000 primary care visits) with 3.1% of patients with a primary care home visit in 2015/16. Notably four of these teams include members of home and community care and/or community agencies. Based on data from the Sunnybrook FHT, the ED visit rate for this population is only 23% (23/101) which is significantly below the provincial rate, demonstrating the effectiveness of our team. In order to further evolve the work of these teams, a more regionalized hub-and-spoke model of care is being contemplated which would attribute patients by neighbourhood geography. Furthermore, our North Toronto home-based primary care teams are now working together to develop an integrated attachment strategy to ensure attachment for all seniors who are unable to access office based primary care due to medical, cognitive and/or social frailty. Our teams are also interested in working together to provide after-hours coverage for urgent needs.

(3) Neighborhood Care Teams (NCT)
The services of our community-based partners, including Primary Care, will be coordinated and distributed geographically through NCTs located in high priority neighborhoods in North Toronto. (Note: specialized care may need other forms of service allocation model). The services of the NCT will wrap around the patients of the Primary Care Providers (PCPs) in the neighbourhood. Excellent work has been completed to date in anchoring interprofessional team-based care to all PCPs in North Toronto that we can leverage.

Year 1 will build on the NCT model already designed for four high density seniors' supportive housing buildings in the Mount Pleasant East and West Neighbourhoods. Team members in these neighbourhoods have a history of working together in similar models and are familiar with the needs of the residents of these neighbourhoods. We will leverage existing assets and relationships. As implementation progresses, the neighbourhood model will be expanded to seniors living in surrounding areas. A hub and spoke model of care may be implemented to leverage the supportive housing sites as hubs for the care teams.

(4) Expanding SPIN / SCOPE / TIP
Care redesign has begun with primary care, and will continue to be enhanced as the NT OHT matures. For example, the SCOPE Program will continue to expand as the primary point of access to hospital and community-based services for primary care providers in the community.

(5) My Healthcare Navigators:
Sunnybrook plans to implement care coordinators/system navigators to transition to community-based care, hospital patients with complex care needs who could be better managed in the community. This service will be supported by a range of specialized interdisciplinary community-based services. Individuals with high risk needs will be flagged based on ED visits/admissions, risk of re-admission, ambulatory care sensitive conditions, limited primary care support and other social determinants of health factors. Once identified, the service will support an integrated hospital-to-home transition across the continuum of care for upwards of 90 days.

(6) LHIN Care Coordinators
We are anticipating the need to plan the transition of LHIN care coordinators to new roles in collaboration with the TC LHIN. Recently, these staff were re-aligned to patient conditions (complex / chronic). We recognize they are extremely knowledgeable and well-trained in assessment and allocation of home care needs.

Under the current model, highly-skilled LHIN care coordinators have little bandwidth for performing the crucial role of helping people get the right care and support, at the right time, or managing a wide range of health and social needs. Going forward, these personnel will perform navigation services as and where needed to supplement the resources currently avaiable within the NT OHT.

Defining Success in our first year
We have defined our key performance improvement opportunities and metrics (see question 3.1). Each will be fundamental to achieving our experience, outcomes, and value objectives, and informing the measurement of our progress in creating a seamless, person-centred care model supported by an integrated care team.

As we consolidate and enhance our programs listed above, we aim to provide our Year 1 population with a “One Team” experience. We intend to monitor and incorporate patient experience indicators, such as knowing where to find appropriate health information, having clear points of contact for questions and concerns, patients/families/caregivers feeling supported, and access to necessary services.

In Year 1, we will reduce service fragmentation and increase connections to ensure a more seamless experience. We will demonstrate success through measuring an increase in the number of high-needs seniors connected to a care coordinator, and an increase in the number of seniors attached to homebound primary care/interprofessional primary health teams with a focus on bringing patients and providers together.

Additionally, we will measure the number of physicians connected to SCOPE/TIP/SPIN which aim to bring providers together so they can work in a coordinated, collaborative way.

Our OHT will aspire to break down barriers by reaching into the homes and communities of our Year 1 population, by leveraging virtual care and digital health technologies.

As we work toward the implementation of our care re-design and metrics, significant effort will be made to establish baseline and measurement structures (where no data exists, a proxy will be used until record level data is available). Once we have a formal structure in place, we will work toward expanding our measurement approach to become more sophisticated over time.

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

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

3.3.1. How do you propose to coordinate care?

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

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

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

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

Max word count: 1000

Our Philosophy

A guiding principle of our OHT is to embed the patient voice in care redesign. Through consultation with patients and caregivers, we have heard what matters most to patients:

- Simple access to services
- Seamless Navigation/Coordination across the care continuum
- Streamlined communication between providers

The OHT will build on transitions of care work that has begun as part of Primary Care Strategy, to ensure patients experience seamless care by providers. Using experience gained through the North Toronto Sub-Region Advisory Council (previously Health Links), our OHT is being built upon a foundation of understanding the importance of seamless, coordinated care. We have also quickly started to leverage and incorporate key learnings from other integrated care models, such as Accountable Care Organizations (ACO), and the National Health Service (NHS), such as:

- Jointly establishing accountability and role clarity;
- Proactive communication and consistent knowledge sharing;
- Work from one care plan that speaks to a patient's care needs and goals;
- Shared digital access on platforms;
- Alignment of resources based on patient and population needs.

There is widespread acknowledgement that health and social care needs are changing as a result of an aging population, with people living longer with multiple, comorbidities and care needs. Patients with complex health needs often require access to an array of health services, often requiring numerous assessments from multiple different professionals. For patients and their families, this can be cumbersome, confusing and often times duplicative resulting in increased difficulty in managing their complex care needs. Transitions of care across many different care settings can be an especially challenging experience for patients, with a rising risk of the patient 'falling through the gaps'. Often family members or informal caregivers provide the only 'common thread' to a long list of health and social care providers.

Our OHT is committed to establishing effective care coordination services and tools to support patients, families and caregivers using a population health approach. To accomplish this, and subject to available resources, we are proposing a graduated system of care coordination that will include three levels of intensity (See Addendum 5 for diagram):

1. Intensive 1-on-1 Care Coordination

At the top of our patient risk pyramid are those with high risk needs who will be assigned a dedicated care coordinator to provide customized support. This service will be provided for patients with highly complex clinical care needs, functional limitations, and/or behavioural health conditions, who are high cost users of health care services. Listed below are examples of intensive care coordination models being explored to serve our Year 1 target population:

a) “My Healthcare Navigator”: Sunnybrook in conjunction with the TC LHIN is launching the “My Healthcare Navigator” program. The program will consist of a team of 4 FTE care coordinators, supported with appropriate case management tools, including access to patient personal health information. “My Healthcare Navigator” will focus on patients with complex needs to ensure the delivery of effective, high-quality, patient-centred care across the continuum of care, from admission to the hospital through to the patient’s return to the community. This program is well positioned for growth and can be scaled as our OHT expands to serve our attributed population.

b) Complex Community Care Coordinators: When patients’ needs are identified as complex/high risk (e.g., co-morbidities, a need for more than one provider, multiple medications, challenging mental health issues, dissatisfaction with multiple providers, etc.), the patient will be connected to a care coordinator by a system navigator (see section 3.3.2 below). Each care coordinator will have his/her own caseload of complex patients. They will have ongoing contact with the patient’s primary care physician (PCP) and other service providers to ensure the seamless and integrated coordination of care. Some of these staff may have expertise in Mental Health and Addictions and behavioural support expertise.

c) Primary Care Enrollment Model (PEM) Care Coordinators: Patients enrolled in certain PEMs have access to care coordinators. These care coordinators provide individualized assistance to patients and families as they move through the continuum of care. They work closely with family physicians and community partners to coordinate timely, appropriate care for patients.

2. Standardized Care Coordination

In the middle of our patient risk pyramid are patients identified as having rising risk needs – patients that follow existing, evidence-based and standardized care pathways or community-based models of care within a geographical area. We anticipate that care coordination assigned to rising risk patients will provide more episodic coordination of care, and may include elements of self-management when appropriate. A good example of a rising risk model that we intend to expand is the Neighbourhood Care Team (See Appendix A).

3. Self-Management

Self-management tools and educational resources will be designed for all patients, families and caregivers within our Year 1 population, with an emphasis on the bottom of our patient risk pyramid (low risk needs). These self-management tools and resources will be easily accessible and adaptable for use in parallel with higher levels of care coordination services for those with escalating care needs. A good example of a rising self-management tool is MyChart™.

For all levels of care coordination, we are anticipating the need to plan the transition of LHIN care coordinators to new roles in collaboration with the TC LHIN. We recognize they are an extremely knowledgeable resource. Going forward, these personnel will perform navigation services as and where needed to supplement the resources currently available within the NT OHT (see Appendix A).

Measuring Success
We recognize that not all patients within our Year 1 population will require care coordination. When they do, it is important to provide services and tools based on their need intensity.

As part of our key performance metrics (see question 3.1), we intend to monitor the number of seniors connected to a care coordinator. By doing so, we plan to increase connections and streamline access for highest-need seniors and their caregivers. If successful, we anticipate seeing an improvement in patient experience, health outcomes, and patient feedback scores with patients, families and caregivers feeling supported.

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

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

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

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

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"One Team" - System Navigators

Our philosophy in health care delivery is based on a "One Team" approach to care. Every person who accesses services through the NT OHT will be able to find the services they need, regardless of the door they enter to access the system.

We envision all people will have access to the healthcare system via their PCP. Embedded in each of our interdisciplinary care programs, including Neighborhood Teams, EPIC,(ICCT and IPCT), House Calls, and CHCs, and assigned to each PCP group (FHTs/CHCs/geographically aligned and solo practitioners), are one or more system navigators (non-clinical) who are the first telephone/e-mail contact for patients and who assist patients with information about available services, provide referral support, and link them to the appropriate providers within the NT OHT and other OHTs.

When patients' needs are complex (e.g., co-morbidities, a need for more than one provider, a need to go outside the OHT for service/care, multiple medications, challenging mental health issues, etc.), the system navigator will link the patient/caregiver with a care coordinator who can support the patient by coordinating and managing the patient's complex care. The system navigator role overlaps in some instances with the role of Social Workers in the community and further planning around the connection/communication between these providers is required.

Effective navigation is a key element of delivering coordinated, patient-centered care and support. Navigators can play a crucial role in helping people get the right support, at the right time, by helping patients access the services they require when they need them to meet a wide array of needs.

Navigators must have comprehensive knowledge of the full array of health and community services available. Like care coordinators, to perform their job effectively they must have access to comprehensive databases providing information about available services, and scheduling, tracking, and monitoring tools. This includes access to patient health information through integrated platforms that form and/or will form an integral part of our near and longer-term plans.

Navigators must be able to advocate for the needs of the patients they serve. They must understand that timely, quality care is essential to recovery. The key purpose of navigation is to ensure patients understand where to go for the care they need. They facilitate access to health and social services as and when needed so patients can experience seamless, integrated care and support.

Our Year 1 Plan / Proposal

Subject to available resources, our navigation resources and services will span across the care continuum from primary care, to hospital and community, including home and community care, and specialists' care. We envision offering navigation services to all patients within our Year 1 target population who require these services. As we continue into year 2 and beyond, we will work with patients and caregivers to continue to refine our navigation services and expand them to support the broader attributed population.

Via Primary Care: Frail seniors will be identified by our attributed PEMs. Ideally, system navigators will be embedded as much as possible within our Year 1 PEMs and will be the first and single point of contact responsible for directing the patient to appropriate

services.
Via Community Support: To support our low and rising-risk seniors, we aim to embed system navigators in North Toronto neighbourhoods and attached to interprofessional care teams. These navigators will act as the patients' single-point of contact and will provide support and streamlined communication across the continuum of care in a coordinated manner. This includes home and community care, community services/supports and social/psychosocial services. System navigators will be strongly connected to primary care and as patient needs change, are responsible for connecting the patient to additional appropriate supports and services to meet the changing needs as required. Some of these staff would have expertise in Mental Health and Addictions and behavioural support expertise.

- Current Chronic Community Care Coordinators (TC LHIN)
- Current SPRINT Senior Care Social Workers
- Current LOFT Community Services Case Management workers

Via Hospital: "Care Coordinators" who are embedded in Sunnybrook and Baycrest hospitals will act as a single point of contact for seniors identified as low to rising risk and who have been admitted to the hospital. These hospital-based system navigators will support patients being discharged from the hospital to ensure they have the required supports and services in place during and after the patient's transition back to community-based care.

- Current Sunnybrook and Baycrest Navigators (TC LHIN)

System Level: Seniors with high risk and complex care needs requiring system-level navigation services (e.g. from hospital bed or ED to home) will be connected to a "My Healthcare Navigator" who will support these patients for up to 90 days following the transition home or to an alternate care setting. They will work collaboratively with any team member across our OHT to ensure the patient's care plan addresses the patient's care goals and that the care plan is shared with all participants in the patient's circle of care. The goals of these Navigators are to: facilitate access to and the participation of all appropriate participants in the patient's circle of care in the care planning, discharge, and transition process; help remove barriers to care and transition; improve connectivity to community-based care; simplify patient navigation through the transition process; enhance the patient experience; improve health outcomes; and reduce caregiver strain.

- "My Healthcare Navigators" = 4 FTEs

As with care coordinators, we anticipate the need to plan the transition of LHIN staff skilled in system navigation to new roles in collaboration with the TC LHIN. The continuing support of these extremely knowledgeable and well-trained personnel is much needed. Going forward, we anticipate these personnel will perform navigation services as and where needed to supplement the resources currently available within the NT OHT (see Appendix A).

Our team will utilize a variety of clinical and patient experience indicators to monitor performance and to inform continuous quality improvement activities (aligned with the quadruple aim as described in Question 3.1).

3.3.3. How will you improve care transitions?

Patients should experience seamless transitions as they move from one care setting or provider to another. Beyond care coordination and system navigation, please identify any specific actions your team plans to take to improve care transitions and continuity of care for your Year 1 population. Describe what initiatives or activities the members of your team currently have in place to improve transitions and explain whether and how you will build off this work in your first year of implementation.

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

Max word count: 1000

Care transitions can be vulnerable points in the provision of healthcare, and managing transitions in care effectively is critical to improving a patient's health care outcomes and health status. As we have heard from our patients, families and their caregivers, they often face challenges in receiving seamless, reliable and timely access to services through periods of transition, and may experience obstacles in transitioning across the care continuum from acute care to home or community care, or from care provider to care provider as health status changes, as a result of insufficient communications, inadequate care coordination and case management, and minimal patient and caregiver involvement.

The effective deployment of knowledgeable, well-trained, and properly resourced system navigators and care coordinators described above and in Appendix A, is essential to the effective management of transitions in care.

To improve transitions in care, as an integral part of the effective engagement of system navigators and care coordinators, we have identified six areas of focus to guide performance improvement in transitions in care:

1) Involve Family, Caregivers and Support System
a. Assess family and caregiver needs
b. Identify caregiver distress
c. Provide interventions for family and caregivers' support (e.g. Respite beds, day programs)

2) Effective Discharge Planning
a. Focus on strengths and goal for recovery
b. Provide useful information that is responsive to what is important to the patient
c. Provide self-care and self-management support tools
d. Effective communications and sharing of patient PHI among all care providers

3) Patient-Centered Comprehensive Care Plan
a. Based on patient-identified, personally meaningful goals
b. Inclusive of all providers of care, working collaboratively
c. Coordinating formal and informal supports
d. Identifying long-term goals, divided into short term action steps
e. Sharing of patient's PHI among circle of care
f. Timely follow-up

4) Ensuring "Warm Hand-offs" when transitioning care
a. Face to face meeting with receiving outpatient provider during inpatient stay or immediately upon discharge
i. Transition planning meeting: outpatient provider, patient, family, and inpatient team (including care coordinators/system navigators)
ii. Individual meeting/session: outpatient provider and patient
iii. 90-day transition period to ensure smooth transition
iv. Timely follow up

5) Consistency with care plan and discharge follow-ups
a. Follow-up phone call to patient/caregiver within 72 hours of change
b. Follow-up phone call to provider
c. 24/7 help line/contact information available

6) Collaboration across the Continuum of Care
a. Engage community partners (including primary care and specialists) across continuum of care
b. Standardize communications
c. Develop protocols for expedited referrals
d. Collaboration on treatment and discharge planning

Consistent implementation of the strategies listed above will improve effective care transitions within our OHT. We will continue the work to connect care coordinators to primary care, specialists, community support services, and hospitals and ensure that patients/families/caregivers of our Year 1 population and beyond are supported.

Our OHT has specific initiatives underway to support seamless transitions from hospital to home. For our "high risk population" who require fully integrated care we will provide:

- Warm handoffs between OHT team members to ensure there are no lapses in care
- System navigators and care coordinators embedded in the hospital and community to facilitate navigation, care coordination, and support for patients both in hospital and in the community (including psychogeriatric/behavioural/addictions expertise)
- Strong connection to primary care
- Digital support that enables data exchange for patient care and facilitates collaboration among team members

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

- System navigation and care coordination, with a strong connection to primary care, to support patients into the community, with integrated team-based care for those who require it
- Community navigation, care coordination and connection to service
- Access to preventative health and health literacy support, through patient, family and caregiver education and training to empower self-management when possible
- Access to digital health record

Care transitions also occur as patients escalate or de-escalate in their health status. Specifically, this means that patients go through transitions in care as they move up an down the population health pyramid. Improving care transitions through this lens will enable us to care for patients in a more integrated manner and ideally keep them well supported in a community / home-based setting.

Measuring Success

To determine progress on transitions, we will measure (as per question 3.1):

High Risk Needs
- Patient feedback scores
- # of patients connected to a care coordinator

Rising-Risk Needs
- % of seniors that have access to interprofessional primary care team
- # of patients connected to a system navigator / care coordinator as needed
- # of CTAS III – V visits

Low Risk Needs
- % of seniors with access to digital health record
- # of patients connected to a system navigator

3.4. How will your team provide virtual care?

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

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

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

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

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

Max word count: 500

Our OHT currently offers a diverse range of evidence-based tools, interactive programs and services designed to meet and adapt to the specific goals and needs of patients, families and caregivers across the care continuum. More specifically, our team currently offers over 80+ programs related to health management and literacy. These tools and programs uphold the principles of inclusivity, respect and dignity to help people achieve their optimal health and wellbeing where they feel most comfortable. Our education and health literacy programs are focused on improving quality of life, encouraging patients to become active and engaged in their care plans, and improving the patient's self-confidence with their condition(s). These programs vary across the following dimensions:

1) size (self, one-on-one, group);
2) modality (in-person, phone, virtual);
3) time (appointment based, Monday-Friday, 24/7)
4) provider (RNs, Physicians, etc.)
5) health condition (chronic, acute)

Specific examples of our programs range from more traditional services such as: Meals on Wheels, Diabetes Management, Transportation, Yoga, and Falls Assessments; to more non-traditional and innovative examples such as: Dietician-led cooking classes (Unison), Virtual Chronic Disease Self-Management with the Interprofessional Care Team (Baycrest), and Elizz (SE Health) which provides virtual support via Caregiver Coaches, and an Artificial Intelligence (AI) chatbot available 24/7/365.

In order to help our attributed population navigate to one of the 80+ specific programs we've identified to date, we are applying a population health approach and plan to link this to specific health conditions that our programs cover for targeted pro-active application and interventions.

High Risk Needs
This patient group needs very structured supports that are high intensity. As such, key features of our programs that are suitable for this group include messaging systems, reminders, portable testing, and e-consults to ensure they are staying on track with their defined care plan. An example of a program would be the Regional Geriatrics Program (Sunnybrook) which provides a suite of services, including home visits to housebound, frail, and vulnerable seniors.

Rising Risk Needs
The next level of patients requires early intervention and diagnosis to ensure their medical needs are being met to prevent them from becoming high risk patients. Programs and services would be designed to promote a more collaborative role in self-management and health literacy including: decision support aids, online, and paper based materials. An example of a program would be the Mid-Toronto Diabetes Program (MTDP) (Vibrant) which provides access to a Diabetes educator, and access to self-management resources.

Low Risk Needs
These patients need tools that ensure the enablement of well-being and a high quality of life. Programs and services would be designed to promote the independence of the patient and engage the patient in an autonomous role/capacity, including: support groups, self-help books, wellness classes. An example of a program is Seeds of Compassion (Unison), targeted at women who are seniors who are healing from a trauma experience.

Overall, we know we have a strong foundation of programs and our work will rely on finalizing our program inventory to validate our current state.

3.5.2. How will you support caregivers?

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

Max word count: 500
"Caregivers" refers to unpaid/informal caregivers who do not receive monetary compensation for the care they provide to patients. The assumption is made here that all relevant legislation including the Substitute Decisions Act and PHIPA will be followed.

Unpaid caregivers play an invaluable role in sustaining our healthcare system. Providing support that enables them to care for their loved ones and themselves is an essential component of our service. The NT OHT is committed to embedding the caregiver experience in the OHT's approach to care. Through engagement with caregivers on the North Toronto OHT's People Centered Care Council and other external caregiver advisors, specific themes on better ways to support caregivers have emerged.

Ensuring that the appropriate level of care is provided to our patients is understood to be the largest contributor to caregiver distress. This fact will embolden the efforts mentioned in this application to improve consistency in high-quality patient care. Many of the other themes that emerged will be captured in the Caregiver Support Strategy the NT OHT intends to co-create with caregivers in our population. This strategy will include ensuring that caregivers are a member of their loved-one's health care team, making available caregiver support information through one central, accessible location, training provider staff to identify caregivers and respond to their distress, ensuring that barriers to care such as transportation are addressed, and creating a standardized caregiver assessment, the results of which will inform a formal inclusion of caregiver needs in the overall care plan. Regular check-ins on the caregiver to respond to any changes in caregiver needs will strengthen our commitment to supporting caregivers to manage their own health. Other themes that also emerged during our engagements are listed below:

Timely and Accessible Communication:

- Continue to improve communication between caregivers and all OHT member organizations involved in care provision. Ensure caregivers are involved in the care plan in a timely fashion (early as possible), are made aware of available options, and made aware of next steps in their loved one's care
- Accessible caregiver counselling and crisis prevention outlets: The NT OHT will look to leverage an already successful 24-hour virtual help service provided by SE Health

Education

- Partner with caregivers to create caregiver training programs that teach necessary skills like performing a bed transfer, falls prevention, etc.
- Joint sessions/workshops that teach health promotion, self-management and self-care, and how to advocate for themselves and loved ones
- Virtual access to information on available caregiver support programs

Respite Flexibility

- Flexible, accessible, variety of respite offerings (e.g. in-home, outside of the home, etc.)
- Larger basket of services for caregiver (e.g. Physiotherapy) as preventative measures to managing their care

Peer Support

- Prioritize removing barriers to accessing support groups and workshops (provide respite for caregivers, different times of the day, different languages, etc.)

- More frequent peer support group meetings

The NT OHT will leverage the caregiver tools, information, supports, help lines, and resources available through the Change Foundation and The Ontario Caregiver Organization to better meet the caregivers' needs.

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

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

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

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

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

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

Max word count: 500

To collectively identify, track, and follow-up with patients, the NT OHT has identified the ConnectingOntario ClinicalViewer as the ideal future-state solution. It represents the best opportunity within the government's inventory today for offering a patient-centric, shared solution, enabling the patient to be identified, tracked and supported by all of the patient's care providers, wherever the patient may access care. However, ConnectingOntario has the following gaps- and we are including suggested improvements that will need to be addressed to support its use as an identification/tracking platform:

- Interface with all OHT partner registration systems, including community support services, homecare providers, and primary and specialist care

- Develop an OHT-specific flagging mechanism to identify the OHT's attributed population

- Expand the timeline covered in ConnectingOntario to capture encounters with community support services, homecare providers, and primary and specialist care providers

- Enhance the identification/tracking solution with push alerts and notifications to the circle of care

• Expand full-access to community support services, homecare providers, and primary and specialist care providers

The NT OHT recommends that eHealth Ontario and the MoH prioritize enhancement of ConnectingOntario to support identification and tracking as a provincial solution that would benefit all OHTs and their patients. The NT OHT is supportive of collaborating with eHealth Ontario and other OHTs in defining the requirements and assisting with the required enhancements to ConnectingOntario. Please see Addendum 6 for the proposed future-state patient identification workflow leveraging ConnectingOntario.

Until the ConnectingOntario gaps noted above are addressed, subject to identification of appropriate resourcing, the NT OHT will use Sunnybrook's BetterCare system to identify and track patients. BetterCare is a system that facilitates identification of patients with complex needs who would benefit from coordinated care planning across participating providers within the OHT. Through a pre-determined algorithm, BetterCare identifies certain high-user patients presenting in the Emergency Department and notifies circle of care providers through real-time electronic alerts. Please see Addendum 7 for an overview of the BetterCare system and how it is currently providing a positive impact on patient care and service utilization.

Subject to identification of appropriate resourcing, BetterCare will modify its algorithm to identify patients based on our NT OHT attribution model. To describe the workflow on how BetterCare will be used, the local registration systems of each OHT partner will be interfaced to the BetterCare system. BetterCare will be able to automatically flag the patient as an NT OHT patient (based on the configured algorithm) and send out alerts via email to providers in the circle of care. Additionally, the email includes a link to a BetterCare user-interface that allows users to view the visit history of patients within the NT OHT. Please see Addendum 8 for the proposed near-term patient identification workflow leveraging BetterCare.

In terms of privacy implications, for access and sharing within BetterCare, we propose a data sharing operations and associated agreement model similar to the way BetterCare operates currently: i.e. agreement to use the HINP service; applicable data custodianship depending on proposed OHT governance structure.

3.7. How will you address diverse population health needs?

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

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

3.7.1. How will you work with Indigenous populations?

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

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

Max word count: 500

Based on the Ontario First Nations Map of Indigenous communities, our attributed population does not include First Nation communities. Nonetheless, we remain steadfast in our commitment as an OHT and member organizations to deliver culturally appropriate and safe care to all communities served, specifically Indigenous communities. Where appropriate, we will partner with and/or seek advice from Indigenous health service providers to deliver services.

SE Health, one of the members of our team, has invested in a dedicated First Nations, Inuit and Métis (FNIM) Program for nearly twenty years. Through partnership and collaboration, the Program works to enhance and support the capacity of FNIM communities across Canada to understand and solve complex health care issues, improve access, and address barriers to care. The Program leverages knowledge and technology to support community-led approaches to health and wellbeing and provide virtual education at no cost to community health care providers.

There are three primary areas of focus of the Program:

- Providing virtual, in person, and vocational training and education to health care providers working in First Nation communities;
- Supporting action-based research to help understand and address gaps and barriers to care and mobilizing knowledge exchange and community-driven approaches to health and well-being; and,
- Advisory services to co-design solutions, including the design of service delivery models, tools and processes and other support resources, with and for First Nations, Inuit and Métis communities.

To date, the Program now reaches 70% of First Nation, Inuit and Métis communities across Canada. The FNIM Program is firmly fixed on creating and maintaining meaningful community partnerships, which requires a high level of mutual trust, respect and collaboration. All content is developed in full partnership with First Nation communities to ensure it is relevant and culturally rich. In addition, an Elder Network provides insight and advice to the Program team as appropriate, as well as guidance in areas of tradition and culture.

Our members have been active supporters of Indigenous Cultural Safety as demonstrated by taking the Indigenous Cultural Safety (ICS) training. Indigenous Cultural Safety training is an online program focused on supporting Indigenous Health transformation as part of the overall health and social service systems transformation underway in Ontario. The overarching goal of the online ICS training course is to begin an important educational journey that will contribute to improved patient experiences; access to health services and improved health outcomes for Indigenous people. Over 100 members of our organizations have taken the training since 2018, and we look forward to additional participation in the years ahead.

3.7.2. How will you work with Francophone populations?

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

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

Max word count: 500

The City of Toronto is one of the 26 French language designated areas in Ontario (Ministry of Francophone Affairs). Of our North Toronto OHT members, Sunnybrook is an identified health service provider (HSP) under the French Language Services Act (FLSA). Our community collaborators include Alzheimer Society of Toronto, a non-identified health service provider which has developed an implementation plan for Active Offer in French Language Services.

Les Centres d’Accueil Héritage (CAH) is one of the partners of the Toronto Seniors Helpline, providing a single point of access for seniors and caregivers to receive information and access to community, home, and crisis services in French. It provides crisis counselling and supportive counselling in French and triages crisis calls to the Crisis Outreach Service for Seniors for in-person visits.

The North Toronto OHT will continue to ensure alignment with the Guide to Requirements and Obligations Relating to French Language Health Services to develop mechanisms to address the needs of its local Francophone community. Our team promotes the principles of Active Offer, as confirmed in our Self-Assessment submitted to the Ministry earlier this year, and endorses obligations and responsibilities to French Language Services. In 2018-19, a total of 215 Francophones were identified as 'French-speaking' and received services across the health service providers (HSPs) in North Toronto. Only 23.5% of the North Toronto OHT has a process in place to 'identify' language of preference for service delivery (OZi Report, 2019).

The North Toronto OHT continues to engage on the Leadership Training on Active Offer, organized by Les Centres d'Accueil Héritage. The goal of this Leadership Training on Active Offer is to support OHTs within the Greater Toronto Area in gaining a greater understanding of the importance of French Language Health Services as part of the Ministry's transformational agenda, which is to provide a connected health care system centred around patients, families, and caregivers, including Francophones. This will help to ensure that all of our partners are made aware of the principles of Active Offer to support the needs and demographics of the Francophone population in Year 1 and at maturity. The principles of Active Offer will be implemented in Year 1 and at maturity to ensure that Francophones have equitable access to services.

The North Toronto OHT, in collaboration with Reflet Salvéo, an organization that facilitates the access to quality French health services for Francophones, has leveraged the needs assessment conducted on seniors and caregivers across the Francophone community. A number of recommendations were made on care coordination and navigation across the health system and these are being considered by the North Toronto OHT in service planning, design, delivery or evaluation as part of Year 1 and at maturity, when more data on attribution of Francophones becomes available.

The North Toronto OHT will continue to leverage collaborative approaches with Reflet Salvéo, and CAH, to develop specific care pathways aligned with leading practices to plan and deliver care for Francophone seniors.

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

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

Max word count: 500

Our OHT is experienced in providing barrier-free access to services to a diverse group of patients, residents and communities. Many of our members have existing programs and services that are specifically tailored to support the unique health needs of marginalized and vulnerable populations. The examples below highlight our OHT's experience and commitment to serving marginalized and vulnerable populations that we intend to learn from and expand as appropriate:

Uninsured Patients
In 2018-19, over 2,800 uninsured patients accessed a variety of Unison's health programs and social services. All CHCs are mandated to service uninsured patientss and they offer those services through their own primary care and social services.

LGBTQ
SPRINT Senior Care has established itself as a leader in older LGBT inclusivity within the community support service sector. They have published a toolkit and guide for other community agencies and organizations to inform and support the delivery of LGBT inclusive and equitable services for older adults. Furthermore, SPRINT and VHA have partnered with The 519, an organization committed to the health, safety and equity of LGBTQ2S community, offering counselling and crisis services, housing support, and social and community-based activities for LGBTQ2S individuals.

Low Income
VHA Home Health Care, LOFT and SPRINT Senior Care deliver several community support programs through its own charitable resources with the support of partners including United Way, City of Toronto, and TC LHIN. These programs are available to individuals faced with financial challenges or who may not have access to financial resources. The House Calls program provides physician-led interdisciplinary care to the most vulnerable, frail, homebound seniors who may otherwise further decline or require a hospital visit. Our partners also work in collaboration with the City of Toronto to connect low income individuals with services to help with health-related expenses such as eye care, dental, medication, medical devices and other health-related supports and subsidies.

Psychogeriatric/behavioural and addictions
LOFT has a suite of services that will be leveraged in Year 1 targeted at our senior population, including: seniors' crisis support, psychogeriatric case management, respite housing, and behavioural supports.

As our OHT continues to learn more about our attributed patient population, we will leverage existing strengths and embed an equity focus to ensure the inclusion of marginalized and vulnerable populations to ensure their unique health care needs are considered throughout care design and delivery.

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

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

Max word count: 1000

Our OHT has adopted the following minimum guidelines to provide guidance in its efforts to achieve coherence in patient/caregiver/community engagement. The minimum specifications will promote best practices in people engagement while allowing for flexibility in participation in planning and delivery to meet diverse needs; specifically:

1) All people whose lives are affected by NT OHT care will have easily accessible opportunity to influence how care is delivered.

2) All OHT member organizations will continually seek ways to co-design care with patients and their caregivers that reflect the diversity of their needs and community.

3) Evaluation of the effectiveness of specific and overall engagement approaches will be continually conducted to inform and improve future strategies.

These minimum specifications will give clear direction to all NT OHT health care providers, organizations, practitioners, and committees to use comprehensive engagement approaches that reflect the diversity of their community.

Of primary importance to our OHT is the advancement and expansion of an already existing culture of patient engagement. A culture of partnership with the community we serve is the foundation which will enable our engagement strategies to succeed.

A current existing example of this is the NT OHT People Centered Care Council. Composed of patient/caregiver/community membership working in partnership with engagement leads from each OHT member organization, this group was created to shape all matters pertaining to patient/caregiver/community engagement for the OHT. Understanding the need and delivering on the task of having the patient/caregiver/community voice at every appropriate table, steering committee and working group is a commitment that the OHT has made and will continue to develop, to ensure a culture of community partnership.

At the OHT member organization level, each provider will continue to partner with the community using the most appropriate combination of engagement approaches. Strategies that will be used include but are not limited to:

- Early engagement in all quality improvement initiatives
- Leveraging technology to enable virtual engagement (external facing Digital Engagement Hub)
- Ensuring the maintenance and support of patient and family advisory councils (PFACs) that are representative of the spectrum of population groups at each of the

OHT member organizations
- Training and orientation/onboarding for new patient/caregiver advisors to increase health literacy and properly equip patients/caregivers to meaningfully engage
- Establishment of two-way communication channels between those engaged at the organizational level and the OHT PFAC
- Recognizing that patients/caregivers often feel more comfortable sharing with other patients/caregivers, we will include patients/caregivers as part of engagement teams

Outreach engagements that seek connections with caregivers/community members that are traditionally more difficult to reach due to a number of barriers to engagement will be implemented. Using best practice strategies, these engagements will focus on removing barriers to engagement and ensuring vulnerable and under-represented groups have a voice (a priority stated by the Executive Leadership Team). Examples of strategies include but are not limited to:

- Leveraging the numerous established local community groups that enable us to engage with groups that have more difficulty accessing or remaining connected to the system. This will allow us to gain a better understanding of the social determinants impacting the health of our communities from their perspective
- Meeting patients and residents where they are, through mechanisms and environments in which they are already comfortable
- Conducting in-person conversations with homebound patients where technology is not an appropriate solution

The NT OHT People Centered Care Council will support the NT OHT by providing oversight and guidance to engagement strategies, and holding the team accountable for adherence to established minimum specifications.

The NT OHT will create a PFAC to support the Executive Leadership Team (ELT) and other health team initiatives. The following proposed guidelines will help shape its structure and function:
- The PFAC will have patient/caregiver representation for all OHT member organizations
- The PFAC will include 2 members of the ELT
- The PFAC will provide 2 to 3 patient partners to the ELT as recommended by the ELT
- There will be a predefined “term of service” for patient partners to allow for other perspectives to be expressed over time and reduce burden on patients
- An established process (co-designed) will be implemented that allows for a two-way communication path upstream and downstream between organizational engagements, the OHT PFAC and the OHT ELT
- PFAC members will be involved in OHT project-focused work at their discretion

Successful engagement will not only adhere to the aforementioned approaches, but it will produce tangible change informed by these engagements. To evaluate the success and effectiveness of our engagement activities, the NT OHT will employ a variety of evaluation mechanisms. These mechanisms will be designed and validated with patients, caregivers, and community members. Some approaches to evaluation are below:

- Patient/caregiver satisfaction surveys for feedback on any care delivered by members of the NT OHT to determine if there are gaps in care, and what ideal solutions would be

- Quality Improvement initiatives influenced by trends noticed through complaints and compliments reporting. This process would also track changes in complaint trends following initiatives to measure impact of the change

- Track improvements that have developed from recommendations given at engagements at all levels (OHT, Organizational, and Outreach). Report on the percentage of change initiatives where patients, caregivers, and community members were engaged and to what degree (following the engagement spectrum)

- Leverage and localize McMaster Public and Patient Engagement Evaluation Tool (PPEET)

- Survey patient/caregiver advisors to determine their experience during engagements

- Engage patient/caregiver advisors at the end of Year 1 to determine who is willing to continue to engage at the same or deeper level with the NT OHT

- Success of the NT OHT engagement will be semi-annually assessed by the NT OHT People Centered Care Council

In the future, as our services become more integrated and we are experienced less as individual organizations and more as a team, our engagement will also seek to evolve. As engagement remains a priority, we will expand our efforts to grow, develop and improve our strategies.

4. How will your team work together?

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

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

Max word count: 500

Our team already has both formal and informal infrastructures in place that highlight our shared goals, values and practices. This has enabled a high degree of alignment with the OHT model's 8 building blocks/components. Specifically, our vision is to become one connected system of health care for people living and seeking care in our North Toronto OHT. This means working together to provide an integrated continuum of care that meets the needs of our population. In the eyes of our community, care will be simple to access, it will be coordinated, and providers will communicate and collaborate as One Team to provide comprehensive, integrated care.

To refine and solidify our plans, we are contemplating a series of workshops to more concretely define a strategic plan for our OHT in the coming months.

To date, our OHT has agreed upon 8 critical goals that were already widely shared across our membership and directly align with the 8 OHT model components. Specifically, our agreed upon goals and alignment are clarified below. (see Addendum 9 for summary table)

NT OHT Goal #1:
Every person is able to access and navigate health care in North Toronto
Aligned with Ministry defined OHT Model Component:
#1 Defined Patient Population
#4 Patient Care & Experience

NT OHT Goal #2:
Every person will have access to primary and team-based care when needed

Aligned with Ministry defined OHT Model Component:
#1 Defined Patient Population
#2 In Scope Services

NT OHT Goal #3:

People will be engaged as health care partners and both patients and providers will be satisfied with the care coordination available to them

Aligned with Ministry defined OHT Model Component:
#2 In Scope Services
#3 Patient Partnership and Community Engagement
#4 Patient Care & Experience

NT OHT Goal #4:
Leadership and governance model will reflect shared accountability and collaboration across primary care, community-based care, and hospital care

Aligned with Ministry defined OHT Model Component:
#6: Leadership, Accountability, and Governance

NT OHT Goal #5:
Providers will be jointly committed to continuous improvement and connecting with social services

Aligned with Ministry defined OHT Model Component:
#8: Performance Measurement, Quality Improvement, & Continuous Learning

NT OHT Goal #6:
Performance measures will reflect population health status and health equity; reflect individual and community experience; track value; and show improvement in what we do

Aligned with Ministry defined OHT Model Component:
#4 Patient Care & Experience
#6: Performance Measurement, Quality Improvement, & Continuous Learning

NT OHT Goal #7:
Investment will be targeted to meeting need

Aligned with Ministry defined OHT Model Component:
#7: Funding and Incentive structure

NT OHT Goal #8:
Every health care provider will be connected as part of one system of care, including primary care

Aligned with Ministry defined OHT Model Component:
#5: Digital Health

While these are an evolving set of goals, they are expressly contemplated in our signed Statement of Intent, and will be further elaborated upon in our governance framework and Participation Agreement that will more formally hold us accountable to these goals.

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

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

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

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

Max word count: 1500

To date the North Toronto (NT) OHT has hosted a number of governance sessions where key board members from each of our organizations have met to discuss how we will build a collaborative governance model, one that is inclusive of patients, family, caregivers, and physicians. We are gaining momentum with our work and have embarked on a path to develop a legally binding Participation Agreement, which will be supported by a governance framework. We are mindful that this work will take time to accomplish and will be iterative in nature to ensure our sustained success. As a result, and for an initial period of time, we will rely on our interim / transitional governance framework which leverages our shared vision (per Question 4.1) and leverages our already signed Statement of Intent (per our Self-Assessment). This interim structure will be championed by the CEOs / EVPs of our Executive Leadership Team (ELT) for their respective organizations.

Shared Decision Making - Conflict Resolution
The ELT will endeavour to reach decisions by consensus. Our draft governance framework will include some basic mechanisms for non-consensus decision-making, including: who are voting versus non-voting members. The Participation Agreement will identify a process for resolution of conflicts which cannot be resolved through a vote of the Participants, as well as a process for how new Participants are added / removed.

Performance Management
As per the Practice Guide from HSPRN (Health System Performance Research Network), we aim to have "inward" and "outward" governance. Specifically, each Participant shall submit an annual attestation of commitment to compliance to the Participation Agreement, as well as a commitment to identify if they have had issues with governance, financial management, compliance with contractual performance obligations, or compliance with applicable legislation or regulation as an individual organization. A process will be developed and put in place to address material breaches of the attestation, with a specified period of opportunity to cure.

In addition we acknowledge we will be collectively accountable for our performance and as such we are working towards a performance management framework that will enable this, and be included as part of our future binding legal agreement. We believe this shared accountability is an essential component of integrated care, and our initial performance measures explained in section 3 will help inform this work.

Information Sharing
Personal Health Information (PHI) level information sharing will be managed via a harmonized / shared health information plan. This will: (1) meet provincial standards of information sharing of PHI; (2) ensure it does not restrict patient choice; (3) support the design and use of a platform for shared clinical and financial accountability and performance management, and (4) promote shared information across platforms. Further details are being discussed on how this can occur via more comprehensive data sharing agreements that respect privacy regulations as we move forward through the stages of our planning for our OHT model. [See Question 4.3.1 for more details]

Resource Allocation
Resources will be allocated via an ELT decision-making process. Not all organizations will have the same level of resources and assets to contribute (people, technology, capital), and there will be allowances made for this that still enable a collaborative governance structure to ensure inclusivity. The end result will be a process of resource

allocation which is equitable, based on the relative size of the organization/member and the role that they are playing in the OHT.

New Team Members
Our OHT is contemplating an initial structure with two levels: Participant at the ELT (“Participant”), and “Collaborator”. “Participants” will be signatories to the Participation Agreement, and will be subject to the following 10 requirements:

I. Commit to the Patient Declaration of Values;
II. Maintain a presence in and commitment to the geographic area of North Toronto;
III. Support community engagement as a core component of all NT OHT undertakings;
IV. Support the Quadruple Aim and value-based and population health-based health care in North Toronto;
V. Observe and comply with the terms of the Participation Agreement;
VI. Contribute to the extent practicable and as agreed upon by all Participants to research, evaluation and best practice initiatives of the NT OHT;
VII. Appoint a Participant representative to the ELT in accordance with the terms of the Participation Agreement;
VIII. Ensure that its Participant representative participates collaboratively and in good faith to advance the purposes and objectives of the NT OHT;
IX. Participate in good faith in the development of a harmonized / shared health information plan; and
X. Be jointly accountable for common performance measures that advances shared and aligned clinical goals along a coordinated continuum of care.

Collaborators will be organizations / individuals that have a desire to participate in, contribute to, and be informed about, the development of the NT OHT, and who are approved as Collaborators by the Participants (i.e. the ELT). Collaborators will be subject to a subset of the 10 requirements listed above.

In order for our NT OHT to succeed and represent our entire attributed population upon maturity, we anticipate new membership at both levels of this framework as a critical success factor.

Of note, as the NT OHT develops towards maturity, we may develop subcategories within “Collaborator” to better delineate each collaborator’s role and the obligations to which Collaborators are subject.

Management
Operationally, our team will be managed by the ELT with several sub-committees, including: Communications, Digital, Operations, and People Centered Care. A project management committee will act as the liaison between these committees to ensure there is a cohesive message and tie-in between groups. This working structure has already been established with Chairs assigned to each committee representing the various Participants. The ultimate decision-making body is the ELT that provides for an equal voice across all Participant organizations. We anticipate that this management

framework will evolve over time as new Participants are added across our governance structure, but also as we evolve our population focus and the need for additional committees arises (e.g. finance, etc.)

Patients, Families, Caregivers
Patients, families, and caregivers are an extremely important voice and are currently represented across each of our committees today. Specifically:
1) we have in place a People Centered Care Council that has provided input and feedback throughout the development of this application, and will continue in an advisory role with the NT OHT
2) we have agreed that individual organizations will continue with their own patients/families/caregiver groups and nominate patients/family/caregivers to sit at the ELT and other committees
3) we plan to review and accept nominations for patient/family/caregiver representatives at the ELT
4) we will start with 2 or 3 patient/family/caregiver representatives who will be non-voting members of the ELT; this will be reviewed annually
5) we will look for innovative ways to give voice to under-represented groups within our OHT

Physicians (Primary Care and Specialists)
Primary care physicians and specialists are an extremely important voice and are currently represented across each of our committees today. Specifically:
1) we have a commitment to a strong physician voice at the ELT

2) we have agreed, where applicable, that physician organizations should continue with their own primary care groups and nominate primary care representative to sit at the ELT. The North Toronto Primary and Community Care Council (PCCC) is a well-developed and long-standing committee that will be leveraged to represent the voice of Primary Care. The PCCC is comprised of representative physicians from all models of physician compensation (including non-salaried providers) and can reflect the issues of all such groups at the PCCC table and through their representatives to ELT. The PCCC has recently opened its membership to allow even broader participation from our community physicians.

3) we will look for innovative ways to give voice to other physician groups (including specialists). Given that most specialist physicians within our OHT are affiliated through credentialing with either Sunnybrook or Baycrest, we will work with the Medical Staff Associations and Medical Advisory Committees at these two hospitals to identify the best ways to ensure an active specialist voice at the relevant tables.

4) we will start with 2 or 3 physician (primary care and specialist) representatives at the ELT who will be nominated by the physician groups and approved by the ELT. The physician representatives collectively will have one vote, to be reviewed annually as per annual review of governance.

In summary, our governance structure and processes will evolve over the coming months as we finalize our Participation Agreement and move toward working together under a single accountability framework and unified vision. We acknowledge that each Participant organization has its own long-standing governance structure which will remain intact. Having this additional governance framework at the OHT level for working together to integrate care will be critical to our success.

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

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

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

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

Max word count: 1500

To enable information sharing amongst NT OHT partners, near-term and future-state workflows have been identified (please see Addendum 10 for data flows).

Near-Term Solutions:

NT OHT will leverage ConnectingOntario as a data-sharing solution to the best extent possible. However, ConnectingOntario has data contribution gaps and challenges that need to be addressed. To support information sharing needs in Year 1, the NT OHT will also utilize a patient-centric coordination of care approach supported by a MyChart Provider Portal specifically designed for interfaced provider-to-provider disclosures, with associated data sharing operations and associated agreements to support provider-to-provider disclosures under implied patient consent based on applicable data custodianship and depending on proposed OHT governance structure.

a. ConnectingOntario ClinicalViewer

ConnectingOntario currently contains acute care data, LHIN data, and access to other provincial assets. While ConnectingOntario is a digital enabler for information sharing, the only data contributors to the ConnectingOntario Clinical Data Repository (CDR) who are NT OHT partners today are Sunnybrook and the TC LHIN Home and Community Care.

Amongst NT OHT partners, the viewing access privileges differs:
• Full access: Sunnybrook, Baycrest, Vibrant Healthcare Alliance, Unison CHC (in-progress), LHIN Home and Community Care workers, and primary care providers.
• Partial access: SPRINT and LOFT (no access to DHDR based on current legislation rules).
• No access: SE Health and VHA are currently not approved health service providers to view ConnectingOntario based on current legislation/practice.

To enable ConnectingOntario as an information sharing tool, the following gaps need to be addressed:
• Data contribution to ConnectingOntario from all OHT partners (inclusive of primary care, specialist care, community support services, and homecare providers)
• Data viewing through legislative changes to either (1) include SE Health, VHA, SPRINT, and LOFTas approved heath service providers to have full access to ConnectingOntario or (2) MOH to provide exception for ConnectingOntario access for SE Health, VHA, SPRINT, and LOFT

It is our recommendation that ConnectingOntario data contribution and viewing access be expanded beyond acute care settings and LHINs to include clinical care data from across the continuum of care. Implementation of legislative changes and technical interfaces to support information sharing will benefit all OHTs and patients across Ontario.

b. MyChart Provider Portal

In addition to being a patient-access channel, MyChart has a Provider Portal where patients can share access to providers to view health records. Subject to identification of appropriate resources, the NT OHT proposes to enhance the MyChart Provider Portal to support disclosures between NT OHT providers under implied consent-subject to patient consent directives where applicable, and subject to any proposed NT OHT governance and custodianship of health information. Through this combined patient-centric approach to sharing information, the NT OHT partners are committed to ensuring that both patients and care givers have access to the most complete set of clinical information possible while adhering to current legal and contractual requirements for these respective data exchanges.

Amongst NT OHT partners, the MyChart patient access channel is already in-use at Sunnybrook and Baycrest (expansion planning in progress) with integration proceeding with SPRINT, VHA, LOFT, and provincial assets such as CHRIS and the Ontario Lab Information System (OLIS). The integration plan to support information sharing through a NT OHT MyChart Provider Portal is to utilize the connections developed for the MyChart patient access channel (detailed in Appendix B 2.2).

Importantly, MyChart architecture includes API supports that will allow other applications to connect and interface with MyChart as required to support both patient and provider data sharing requirements. API connectivity will be explored amongst partners to ensure providers have access to MyChart information in the most efficient way possible.

c. Key Gaps/Challenges

In addition to the gaps for contribution and viewing noted earlier, a key gap exists in primary and specialist care contribution to both MyChart and ConnectingOntario. Outbound interfaces from primary and specialist care EMRs to MyChart and ConnectingOntario have been limited. To mitigate this gap for Year 1 purposes, the NT OHT care team proposes a new documentation process that will engage the care team's healthcare navigators and primary care providers in regular communications and the documentation of notes by the navigators into their local point-of-care applications. With the notes from healthcare navigators documented in local point-of-care applications (including primary care updates), these will be integrated with MyChart, enabling the primary care provider information to be shared across NT OHT providers.

The ideal solution is for primary and specialist care EMR data to flow directly to MyChart patient and provider platforms and ConnectingOntario through outbound interfaces. To do this, the NT OHT is dependent on OntarioMD and the EMR vendors to enable information sharing. The NT OHT is supportive of collaborating with OntarioMD, the leading EMR vendors, and other OHTs in defining the requirements and assisting with the required enhancements to accomplish this interfacing.

Future-State Solution

a. FHIR integration

The future-state solution for information sharing envisioned by the NT OHT partners is for all partners and vendors to align with the Digital Health Information Exchange Policy. Subject to identification of appropriate resources and vendor capability, the NT OHT partners will support FHIR interfaces and APIs between our local point-of-care applications. Through FHIR, each NT OHT partner will be able to access shared information efficiently. Key feedback from clinicians is they would like an integrated solution and not one that would require them to navigate to/from multiple applications. Through FHIR integration, we will achieve a future state that allows providers to access information efficiently and directly through their local point-of-care systems.

Privacy Considerations

Sunnybrook, LOFT, SPRINT, Vibrant, Baycrest, Unison, LHIN, SE Health and VHA are all HICs. Each has the legal authority to collect, use, and disclose personal health information (PHI) for the purposes of providing health care. When data is to be used for administrative or secondary use purposes, we will ensure that patients and/or their substitute decision makers are aware of the sharing of data with consent, where applicable.

For the near-term and future-state solutions described above, the following privacy safeguards and requirements have been identified:

a. MyChart:
• For patient or non-patient delegated access to MyChart: the existing patient and non-patient 'Terms of Use' would likely be appropriate, subject to legal review.

• For site onboarding to the MyChart patient access channel:
i. the existing site SLA enabling interfacing with MyChart would likely be appropriate, subject to review.
ii. a privacy and security assessment to be undertaken for each site by the designated OHT entity (i.e. whoever is operating the MyChart PHR in the OHT context).

• For site onboarding to the MyChart 'Provider Portal:
i. A privacy and security assessment to be undertaken for each site by the designated OHT entity (i.e. whoever is operating the 'MyChart Provider Portal' in the OHT context).
ii. Review and revision of appropriate data sharing agreements, patient consenting requirements and patient/provider Terms of Use as required.

b. ConnectingOntario:
• For onboarding to ConnectingOntario, each site needs to complete the standard eHealth Ontario ConnectingOntario privacy and security assessment
c. FHIR integration:
• In the future, when FHIR is adopted as the standard for information sharing, integration between partner sites will require appropriate data sharing agreements that will be determined based on the OHT Governance structure

In order to protect patient information, the NT OHT is committed to implementing safeguards in alignment with the Digital Health Information Exchange Policy and Digital Health Reporting and Performance Policy, to:

a. Harmonize the privacy and security policies, procedures and practices amongst our participating partner sites with respect to operations conducted within the governing framework of the OHT.
b. Take reasonable steps to ensure that patients understand any information practices that relate to the operation of the OHT, and how these may differ from the practices of any individual site when it may operate independently.
c. Comply with any and all privacy and security policies associated with provincial

and other digital health assets that are utilized by the OHT and/or participants.
d. Consider leveraging OntarioMD Privacy and Security Training and resources to support our understanding and compliance with privacy and security requirements.
e. Put in place and maintain policies, procedures, practices, and agreements that are necessary to enable the NT OHT partners to comply with legal and regulatory obligations (including those under PHIPA) and with other relevant policies, and coordinate privacy operations such that a patient served by an OHT:
• may make a request for access, correction or a consent directive just once to any OHT partner, and receive a response that addresses any affected PHI, regardless of which partners are custodians of that PHI.
• may pose a question, make a complaint or report a suspected breach of privacy or security to any OHT partner, and he or she will receive one response, regardless of how many participants may need to contribute to that response.
f. Identify and mitigate privacy and security risks and areas of non-compliance in respect of NT OHT partners' connectivity with provincial digital health assets.
g. Report on a limited set of privacy and security performance and accountability measures on a quarterly basis to facilitate provincial tracking of digital health maturity.

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

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

5. How will your team learn & improve?

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

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

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

Max word count: 500

Our individual team members are committed to learning and continuous improvement, and we see the OHT model as an innovative venue to accelerate our learning together as a team.

As part of the submission of this application, our individual team members have attested that they have no known issues of governance, financial management or compliance with contractual performance obligations or compliance with applicable legislation or regulation.

We plan to formalize this via an annual declaration process that will be further contemplated in a more legally binding manner via our Participation Agreement. This will involve the required signing of an annual attestation of compliance that brings transparency around individual member performance.

If concerns around these concepts arise in the future, we would seek to address them via our Executive Leadership Table through collaborative discussions. Using the lens of our Participation Agreement, we will clearly outline a process to resolve such matters via conflict resolution, quality and performance standards, and an evaluation framework.

We firmly believe that working together as a team to serve our patient population will help us leverage each other's strengths in a complementary manner more so than we could as individual organizations.

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

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

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

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

Highlight whether any members of your team have had experience leading successful cross-sectoral or multi-organizational improvement initiatives.

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

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

Max word count: 1000

Our OHT has been leading successful cross-sectoral and multi-organizational improvement initiatives for nearly a decade. Accomplishments in collective application of quality improvement (QI) techniques and using data to demonstrate performance improvement (PI) are shown in three domains. Our commitment to collaborative quality improvement as members of the proposed OHT demonstrates our readiness and ability to attain the next stage of maturity in integrated care.

(1) Collaborations for Better Managed Care
BetterCare and Coordinated Care Plan (CCP) are examples of the North Toronto Advisory Council's continuous QI on collaborations to manage care.

Sunnybrook worked together with NT OHT members to develop "BetterCare", a system to electronically identify high-frequency emergency department users and notify primary care and community care providers. Using a pre-defined algorithm, patients arriving at Sunnybrook who meet the algorithm are flagged by the system, triggering the initiation of the CCP process with the primary care and Community Health Center providers. The members review BetterCare flags and patient progress monthly. BetterCare was able to show performance improvement in several QI experiments using one-time funding. The funding was given to community partners to deliver ED-diversion programs. Specifically:

a) 91% of Sunnybrook ED patients engaged in the ENCOMPASSED experiment reduced their ED visits; reductions ranged from 38-53%.

b) LOFT-EMS reduced avoidable ED visits from a rate of 32% to 11%.

c) To-date, our NT OHT members have developed more than 2,763 coordinated care plans and 80% of patients surveyed would recommend the service to other patients.

(2) Enhance QI Capabilities Across Member Organizations
Our OHT members have engaged two cross-sectoral multi-organizational IDEAS cohorts. IDEAS (Improving & Driving Excellence Across Sectors) is Ontario's provincial quality improvement training program for healthcare professionals. Emerging leaders from community-based organizations and citizen representatives applied their training to navigating 12 caregivers in 2017/18 and engaging 87 residents of two Toronto Community Housing buildings to inform the development of the Interprofessional Primary Care Team in 2018/19.

Broadly, our QI and PI processes rely on interdisciplinary teams empowered to set improvement goals and identify barriers in care design using Plan-Do-Study-Act cycles with targeted quality measurements. Notably, all of our organizations are accredited or will be accredited by end of calendar year. Accreditation Canada emphasizes QI in its evaluation and to date, all of our partners have a designation that is exemplary in standing with Accreditation Canada or other accrediting bodies.

Our teams draw from a range of tools including: Quality Improvement Plans (QIP), Process Mapping, Lean/Six Sigma, Time-limited QI projects/initiatives, Check List/Sheets, Dashboard/Key Performance Indicators, Enterprise Risk Management, Structured Individual Feedback/Engagement, and Root Cause analysis (e.g. Fishbone Cause & Effect). As a result, we would characterize our collective OHT as being proficient/expert with this work, given the many decades of experience we share. This self-rating of proficient/expert is similarly true for our experience and capability for data analytics.

Individually, each of our organizations have PI / QI capabilities, with some being more formalized and others less so. By virtue of organizational size and resources, hospital care, home and community care, and home care agencies have established decision support teams, PI/QI teams, and research teams with dedicated FTEs. Community agencies and primary care have smaller infrastructures / capacity to manage this work, however, are well-versed and proficient in their own domains. Given this contrast in supports and available resources, we recognize the importance of leveraging our collective efforts to ensure there is cross-pollination of QI / PI and data analytics capabilities for our OHT. We acknowledge that we can learn from each other's successes and failures in healthcare quality improvement.

Those members who create annual board-approved quality improvement plans have adopted the goal to create collaborative quality improvement plans.

- Baycrest's 2018/19 QIP: focused on screening and offering ambulatory patients a CCP (100% screened were offered a CCP in 2018/19).
- Sunnybrook's Palliative Care QIP 2019/20: Sunnybrook is leading the North Toronto Sub-Region Palliative Care Journey Committee.

(3) New Services Advancing Quadruple Aim
Our OHT is at a stage in its QI capability that members can collaboratively create new services with ever expanding partnerships.

(a) Pine Villa: Sunnybrook, LOFT and SPRINT Senior Care established and operate Pine Villa, a short-term transitional care site. The aim is to reduce hallway medicine by diverting ALC utilization to community settings. Prior to the opening of Pine Villa, Sunnybrook was caring for an average of 86 ALC patients each day (with peaks nearing 100 ALC patients), critically impacting its ability to provide acute care services. From February to June 2018, there were 109 referrals to Pine Villa, with 88 acceptances.

(b) Interprofessional Primary Care Team - The North Toronto Interprofessional Primary Care Team is mandated to attach more patients to primary care. The team struggled to understand why people were using the health system episodically at walk-in clinics and emergency rooms and so they initiated small tests of change. The team immediately delivered minimally viable health services to patients in building lobbies, food banks, community centers, reactivation centers, private homes, physician offices, virtually, and in hospitals. From experience and relationships the team received qualitative (informal and formal interviews, focus groups, organization-to-organization meetings) and quantitative (polls, screening clinics) feedback on how to improve performance. This in addition to formally facilitated co-design events and embedded patient and family partners crafted the next sprint of improved service delivery and learning. The team and its partners across sectors has served 800 people in a year and collaborated with 26 organizations.

(c) Seamless Care Optimizing the Patient Experience (SCOPE) – a virtual interprofessional health team that supports primary care providers through a single point of access. North Toronto quickly met the target of having 75 primary care providers enrolled in SCOPE in the first year through quarterly tracking of enrollment and monthly primary care use of SCOPE.

Overall, we believe our OHT is well positioned for sharing quality improvement initiatives that help to improve integrated patient care and system performance.

5.2.2. How does your team currently use digital health tools and

information to drive quality and performance improvement?

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

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

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

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

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

Max word count: 500

Our team has used a variety of flexible engagement approaches to collaborate with patients, families, and caregivers (unpaid and paid) to improve transitions, care coordination, palliative care, patient experience, caregiver support, and virtual care and to positively impact health and well-being.

We gather feedback and input via: advisory councils/groups, surveys, suggestion boxes, town halls, focus groups, virtual engagement, participant observation, and interviews. Other patient engagements include: participation in quality improvement initiatives and strategic planning, training and hiring of staff, care mapping, co-designing/redesigning care pathways, case conferences and workshops.

Each team member measures patient experience and has a patient-relations process to help identify opportunities for process and system improvements and to better meet the needs and expectation of patients and their caregivers. Results are used to monitor performance and help inform quality improvement initiatives including service and practice change.

The following examples will highlight the breadth of our team's experience in engaging patient/family/caregiver input to ensure a people-centred care* approach to improving aspects of care:

- Working with cardiac patients and their caregivers to improve the transition from hospital to home, a care process pathway was designed to streamline access to follow-up care, enable faster discharge, and provide better community-based supports. Subsequent evaluation conducted with patients, caregivers, and staff identified the need to further reduce patient and caregiver anxiety by improving the approach to patient education. Educational materials were re-designed using health literacy, self-care and self-management principles.

• Working with hospital inpatients by asking them to answer three questions about their experience resulted in survey data that is being used to improve patient inpatient experience. A new oral hydration initiative that allows patients awaiting surgery the chance to consume clear fluids closer to their surgery has improved patient inpatient experience and reduced the median percentage of time patients are fasting from food and fluids pre-operatively.

• Working with patients and caregivers with experience in palliative/end-of-life care at home, process mapping was conducted that identified the need for improved communication, improved access to care coordination, and expedited service improvements. The following improvements resulted: designated online palliative resources, a designated phone line with a priority number to reach nurse/coordinator, and a co-designed quality visit survey that collects feedback during service to identify the need for rapid improvements to current service.

• Working with patients, family, and caregivers who have experience with community services led to improvements in patient experience and virtual care. Collaborative work at Patient and Family Advisory Council meetings created and improved policies and patient communications, positively impacting patient experience. Using a co-design approach, virtual home assessments were developed that provide physicians with a “window into the home” and support patients and their caregivers to better care for themselves at home.

• Working with patients with mental health challenges and homebound individuals, where technology is not an appropriate solution, flexible engagement approaches such as individualized home visits and meeting at programs where the individuals are comfortable has been used to obtain feedback and input for QI.

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

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

Max word count: 500

Our team engages with a broad network of community groups and works cross organizationally to improve strategic, policy and operational aspects of care. Outreach to vulnerable populations and engagement via: existing networks, advocacy, peer-led/volunteer groups, and formal community partners (e.g. primary care) has fostered relationships between diverse groups. Through flexible approaches, groups facing barriers to participation in patient engagement have had their voices heard and their needs included in care redesign.

Our recruitment of community members on organizational boards and committees helps ensure a community perspective in governance and operational work via focus and advocacy groups informs strategic plans and operating procedures.

The following examples highlight the breadth of our team's experience engaging and collaborating with diverse community groups, including those with poorer health outcomes, to improve aspects of care:

- Working with a Hoarding Support network of: patients, caregivers, community-based organizations, the City of Toronto, Sunnybrook Hospital, Public Health, Paramedic services and volunteers, a collaborative initiative created a public website and ongoing education to influence the delivery of quality services and care that is respectful and non-judgmental of patients' homes and possessions.

- Working with LGBTQ2S community groups via: stakeholder advisory, advocacy and working group engagement led to a safer living environment in community housing for a group undergoing gender transition, and for people receiving services at home in the community. An award-winning housing program, BLOOM, was developed to support the group who were gender transitioning. Improved safety and LGBT inclusivity in the community, via: revised polices, a new LGBT seniors' social drop-in, agency-wide training and a "how to" community resource for LGBT inclusivity was developed and shared widely.

- Engagement with patient advisors, primary care and community groups (community, home care, and mental health providers) led to collaborative strategies to improve patient experience and outcomes for emergency department patients. Integrated solutions such as embedding community social workers and transitional care leads in the emergency department to support 'wrap around' care for patients are being developed to ensure consistency in quality and access to services across the system as patients transition from the emergency department back to the community.

- Engagement with community groups including financial, housing developers and research associations, City of Toronto, OPP, Toronto Public Library, and community health provider groups on housing for palliative and end of life care led to the new Journey Home Hospice in Toronto, an innovative, end-of-life care model for patients experiencing homelessness. A Community Advisory Panel, including homeless individuals, and palliative care champions, has informed inclusivity training, the care model, and helped brand public materials. Home Hospice volunteers with diverse personal, professional and socio-economic backgrounds provide ongoing feedback on patient care and community needs.

- Engagement with advisory groups and a planning committee of patients improved relationships with neighbourhood seniors and led to the following initiatives for groups facing barriers to health: a peer-led outreach to vulnerable seniors isolated at home, a new social group, improved cross-team conferencing between primary care and health promotion teams and the creation of a food cupboard with personal hygiene supplies.

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

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

Max word count: 500

We understand that one of the core building blocks of the OHT model at maturity involves teams being funded through an integrated funding envelope based on the care needs of our attributed patient population. In Year 1, we anticipate having individual funding envelopes remaining in place as we improve our understanding of our population's cost profile.

We feel well positioned to manage cross-provider funding for integrated care in the longer-term, and have several examples to demonstrate our successes to date:

1) Pine Villa: In 2018, Sunnybrook, SPRINT Senior Care, and Loft Community Services partnered to manage a ~$8M budget for Pine Villa. This is a 68 bed transitional supportive housing site located in North Toronto. This partnership leverages expertise from hospital, mental health and addictions, community support services and VHA to care for patients who do not require an acute care setting but need continuing support for a period of time prior to returning home. Additionally, Pine Villa is home to a community-nursing clinic led by the TC LHIN.

2) Bundled Care: Sunnybrook has been in discussions with SPO agencies through the development of the bundled care for Hips/Knees, CABG, and Stroke. This involves Sunnybrook acting as the single fund-holder for care across the entire continuum. Significant infrastructure is being built and learning has been codified and captured that could be transferred to our OHT.

3) Integrated Community Care Team: This a collaboration between Baycrest's Geriatric Outreach Team, North York General's acute and Geriatric Emergency Medicine, solo family physicians and the Department of Family Medicine at Baycrest, the Central and Toronto Central LHIN Home and Community Care. Each organization

contributes FTEs to the team such that complex homebound geriatric patients in our shared catchment area experience "one team". Baycrest as the lead agency distributes the funds and holds contracts for in-kind contributions. A steering committee made up of service providers monitors performance and collaborates with Baycrest as the organization that is ultimately accountable for outcomes.

4) Community Programs:

a. Toronto Ride (TR): SPRINT is the lead agency for the Toronto Ride partnership, which is a collaborative of 13 not-for-profit partner agencies providing transportation service to seniors and adults with disabilities in the City of Toronto. The goal is to provide a consistent level of service to patients while ensuring a high-quality individual experience. SPRINT manages the software scheduling system for all TR member agencies as well as the TR phone line and website that provides a single point of access for all patients.

b. House Calls: an innovative, interdisciplinary, community-based comprehensive and patient-centered home-based primary care program serving frail homebound seniors and long-term care eligible older adults in the TC-LHIN. As the health service provider with a service agreement with the Toronto Central LHIN, SPRINT serves the role of lead agency for the purpose of ensuring accountability to TC LHIN for service delivery and management of funding. SPRINT contracts services from VHA, and manages the team's TELUS EMR.

Overall, we have demonstrated a track record of responsible financial management.

6. Implementation Planning and Risk Analysis

6.1. What is your implementation plan?

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

Max word count: 1500

In Year 1, we will focus our efforts on local improvement that places emphasis on the quadruple aim as well as enhanced access, communication, navigation and coordination of care for our attributed population. This means providing comprehensive access to integrated care for our Year 1 population. At the same time, we will establish a robust population health management system – building on our strong understanding of our neighbourhoods and sub-populations to ensure comprehensive and inclusive system planning. This will allow us to address seniors who are moving from low risk to high risk before they become at-risk, and avoiding inappropriate hospital use. Our core implementation priorities include:

1) Co-designing with Primary Care: We will work to build bridges with a targeted number of primary care enrollment models (PEMs) that are attributed to our OHT. By focusing in on a select number we can target interventions, and build solutions to show tangible results more quickly that we can replicate. We acknowledge this will move at the speed of trust but we believe we have strong momentum with many PEMs to start.

We will also work to expand our reach for our existing primary care services and assets at Vibrant Health, Unison, and Interprofessional Primary Care Model (developed by Baycrest Hospital; used in Toronto Community Housing Corporation buildings and Pine Villa). These specialized primary care models are customized to address the needs of unattached, complex, vulnerable, marginalized, and racialized populations, particularly those residing in social housing communities and known to be frequent users of hospital emergency rooms.

2. Demonstrating Home Care Re-Design: We have launched Neighbourhood Care models in several areas in North Toronto and will extend these implementations where appropriate. Through this model, we are focusing on hyperlocal integrated care planning for vulnerable populations; ensuring patients have access to a strong interprofessional team that includes primary, home and community care. This will represent our foray into home and community care re-design as a microcosm demonstration project to test out our proposed system planning efforts.

3. Enabling Digital Care: The NT OHT is committed to implementing our digital health plan, subject to approval of resources. Implementation timelines will be finalized collaboratively to achieve our near-term and future-state solutions to support information sharing, patient access, and identification/tracking of patients. We will continue our dialogue with other OHTs to ensure a common inter-operable solution is contemplated.

4. Confirming Governance: We continue to build our governance framework and it will be of heightened importance as we start a focused governance committee to support in depth discussions. We will be building out how we can design a collaborative structure that is inclusive, nimble, and has the appropriate authority to enable system change.

5. Engaging Community, Families, Patients and Caregivers: We are planning broader community engagement events that will look to our attributed population for feedback on a strategic plan for our OHT work.

As we improve care for seniors in Year 1, we will be able to leverage the established processes to identify opportunities and make meaningful change for other population segments. This will continue to be based on the successes we achieve based on the Kaiser Permanente pyramid population health management model. Notably, we will continue to build on our strong foundation as a connected and accountable network of providers and integrate our services and assets to unlock capacity. Below is a high-level snapshot of what we intend to accomplish at the 30, 60, 90 day and 6-month marks.

Our work has already begun today and will continue in earnest. Below is a more detailed plan that highlights some of the key workstreams. However, these are subject to change, based on a number of dependencies.

In the next 30 days we plan to:
• Start the development of a roadmap. This will involve a series of workshops with senior leadership across our membership, including patients, families, and caregivers. This will provide the formalized structure that we need to build upon our collective understanding of our work and will be based on our shared vision.

• Kick off our governance planning committee. We are confident that our statement of intent and work to date, and historical relationships will ensure that we can come to consensus on how we will build a strong framework to support the services we intend to provide.

• Accelerate engagement with primary care. We plan to continue to solicit interest from our primary care enrollment models that are attributed to our OHT. We are targeting 3-5 PEM models to ensure there is a strong base of support that we can nimbly make decisions with and involve in co-designing our efforts.

In the next 60 days we plan to:
• Seek external engagement in the development of our strategic plan. We will seek broader community input with a series of engagement activities and events to elicit feedback to help us to refine and sharpen our focus on the concepts that matter most to our population. Once we complete this step, we will be able to formally start a strategic planning process.

• Review record level data and develop baseline and targets. We anticipate doing a deeper dive into record level data of our attributed population as part of our strategic planning work. This deep dive will include a macro level population segmentation exercise which will help define our baseline for our key performance metrics that we identified in question 3.1, and allow us to start to build a measurement infrastructure along with realistic targets. Once we complete this step, we will be able to formally start our re-redesign process.

In the next 90 days we plan to:
• Conduct internal stakeholder engagement. Change management and communication internally with our teams will be critical. Our process to do this will involve an education campaign, supported by web and social media to ensure we are able to reach a larger audience. As part of this work, we will advance our thinking around a central brand.

• Validate service inventory and deep dive into our care redesign and gap analysis. Our service inventory will be confirmed and reviewed. Any gaps will be highlighted and re-design opportunities will be highlighted. Recommendations for investment and expansion / consolidation will be considered at this time. Once we complete this step, we will be able to re-confirm our membership and collaborators in a more holistic fashion.

In the next 6 months we plan to:
• Implement our redesign plans. (See Question 3.2). By this time, we anticipate having had 3-4 PDSA cycles across some of our signature initiatives. We will seek out new opportunities as they arise and look for meaningful improvement in care for our Year 1 population.

6.2. What is your change management plan?

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

Max word count: 1000

As we embark on our journey in becoming an Ontario Health Team, the North Toronto OHT has devised a change management plan that is based on embedding the following principles to support the implementation and ensure ongoing success of delivering integrated care to our community and patients:

1) Commitment to a culture of collaboration
To ensure transparent and open communication, the NT OHT has established an ‘all voices matter’ approach and will seek out opportunities to include patients, residents,

families, caregivers, physicians and other providers along every step of the way. This will help to build new and strengthen existing relationships, while ensuring an inclusive and diverse approach as we work together to co-create a health system that will meet the unique health needs of our population. This is demonstrated by:

Our proposed governance structure, whereby our Boards of Directors have agreed in principle to collaborate and explore opportunities to work together under one accountability framework as we move towards maturity, including performance and funding mechanisms. This is a significant shift from the current healthcare landscape, and can only fully be achieved by moving at the speed of trust. By fully committing to this type of collaboration at the governance level, we will position our OHT to not only be successful now and in the future, but also to be a leader in integrated care governance, design and delivery.

Our Patient Centered Care Committee, a panel of members from each respective partners' resident and/or patient and family advisory councils, as well as primary care providers is working hand in hand in designing the future of the North Toronto health system based on their current needs.

2) Build effective coalitions
Since the outset of our work under the North Toronto sub-region, our partnership has worked to break down silos, and to build trust and consensus as we continue to work together to achieve our common goal of building an integrated health care system. We know that together, we can accomplish objectives beyond the scope of any single organization or entity, and can achieve a widespread reach within and across communities.

This is evidenced through our efforts to build a highly effective coalition with our Primary Care Providers (PCPs). To accomplish this, we are leveraging our Sub-regions' Primary and Community Care Committee (PCCC) and have engaged physician champions to provide strategic leadership and guidance to our OHT. Specifically, their focus is to unify the voice of PCPs, advance relationships with other PCPs, and ensure there are accessible mechanisms to provide input into OHT initiatives that affect their patients. Raising awareness, having an open engagement strategy, and ensuring the voice of primary care is heard will be crucial for change management. The North Toronto Primary and Community Care Committee, along with the Primary Care Sub-Region Team, will continue to work with Primary Care to better understand the challenges in their practice, and to help implement solutions that would be easy to embrace, solutions that benefit PCPs as well as their patients. In doing so, we are working to better connect our PCPs with our acute, home and community care partners.

3) Centralize project efforts
In order to streamline efforts, our team has established a centralized project management team to effect change and ensure alignment of our OHT's progress and work plans. This team will continue to be critical in building central competencies, establishing and maintaining consistency, embedding our OHT's vision, and ultimately

to support its successful implementation.

4) Make improvements through evaluation
Evaluation is critical to understanding and determining the impact of our OHT and its associated suite of programs and services. By continuously leveraging key performance metrics and soliciting constructive feedback from our partners, including patients, family members and caregivers, we will make necessary adjustments to allow for and enable improvements to the quality of programs and services delivered. Additionally, we have already partnered with other neighbouring OHT candidates and have created a forum to share successes, best practices, and lessons learned.

Lastly, we also know that many other work streams will require more rigorous approaches to change management, both internally and externally, such as our proposed digital health and information management streams and future clinical re-design, whereby work flows may be impacted. We will remain nimble and flexible in our change management approach to adapt to the work streams as appropriate to ultimately ensure the success of our OHT.

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

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

Max word count: 500

Within our ~178,000 attributed patient population we have identified approximately ~34,000 seniors (65+), of which we are targeting ~10,000. The fact that we are not targeting all ~34,000 seniors in Year 1 is a reflection of the notion that we must be practical and careful to show impact and to quickly scale effective interventions and spread. The remaining ~24,000 will continue to receive excellent care and will still be able to access programs and services as they already do today.

Specifically, our performance measurement plan (see Question 3.1) tracks and monitors performance and would be a signal to ensure care is provided to all patients in our Year 1 population. However, our care does not stop at our Year 1 population. Each of our OHT partners has programs and services that will continue to be funded and remain wholly intact to ensure full coverage of care. We are focused on re-aligning existing programing and weaving together our assets in a way that enables us to be more efficient while still providing excellent care for all the patients we serve (whether they are part of our OHT or not). In year 2, we plan to expand our ~10,000 patient focus. (See Question 2.9.)

It is noteworthy that our OHT members serve a large number of patients well beyond our attributed population of ~178,000 patients. We act as regional / specialty care providers for a geography that extends as far as the borders of Ontario. Moreover, we are an urban centre OHT that is deciphering the unique challenges of caring for patients that are well beyond our attribution model. We acknowledge and respect the need for patient choice in all of our work.

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

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

Max word count: 1000

Below are some of key structural/systemic barriers that our team foresees that may impede upon our ability to successfully implement our care redesign plans:

Financial

- Single Funding Envelope: Managing a single funding envelope across multiple partners creates unique challenges including: back-office supports, monitoring, reporting, audits, and compliance. Today with bundled care there lacks a strong system of support to manage all the requirements from the MoH and we imagine this would be exacerbated. There will also need to be discussion about how funds and accountabilities for delivery of services are distributed for patients whose care crosses OHT boundaries (i.e. a person attributed to one OHT receives community services from another OHT).

- Digital: Development of digital asset integration to facilitate information sharing amongst OHT members and between OHTs within the Greater Toronto Area will require financial resources. These include investments to support a shared record, identification/tracking, patient access, and virtual visits. There should also be more focus placed on inter-operability of systems between OHTs (especially urban OHTs)

Operational

- Urban Centres & Attribution Methodology – Hospitals in urban centres are challenged by the attribution model as our patients are not confined within a local catchment area and easy to track. This is a result of patient choice; for example, residents working in Toronto may be attached to primary care in Toronto but live in a different geographic district. Working through the challenges of how to develop an infrastructure of cross-billing and managing relationships with other OHTs will be a significant barrier. Additionally, we noted that there are limitations to the current attribution model in that: CHCs, and LTC are not included in the modelling, making more difficult the task of taking an attributed population-based approach to our work.

- Staffing / Resourcing – Creating a management team for our OHT and appropriately resourcing this without further funding creates significant barriers to redesigning care, and this work is being added to already stretched resources.

• Expected shortage of family doctors – North Toronto is not designated as area of high physician need outside Lawrence Englemount. This means new physicians are unable to join a FHO unless replacing a retiring or deceased physician. New graduate physicians can join through New Grad Entry Program but reporting requirements and rostering requirements are onerous. This leaves physicians struggling with health challenges or retirement planning struggling to obtain coverage. The current 1 to 1 replacement does not address the differences in new physician's roster size and departing roster size. We are now left with inadequate succession plans as the population in North Toronto grows due to the addition of many new condominiums, coupled with a number of primary care providers in North Toronto approaching retirement age.

• IT / IM solution: Without a single system to help identify, roster and track attributed patients, OHTs will need to dedicate resources to build solutions which may or may not be inter-operable with other OHTs, creating the potential for significant challenges. Additionally, there are financial barriers associated with building and investing in a digital platform within our OHT without additional resources.

• Change Management: Lack of time built in for change management and general awareness of what these new policies and legislative requirements mean to front line staff, can impede effective planning.

• Data Package: Inability to track / log patient information at the record level can impede the ability to plan, re-design, and manage care. The data will need to be able to be linked to other data sets to be able to predict growth and changes to the attributed population.

• Procurement and Contract Management: Existing supply chains are not necessarily all the same across OHT members, creating challenges around supporting procurement for services, supplies and equipment for an OHT.

• Patient voice: Lack of an existing unified voice/body that is representative of the fully attributed population will delay our ability to obtain fully representative patient input into the process.

• Unified physician voice: Lack of an existing unified voice / body that represents the fully attributed primary care and specialist providers under a single accountability structure will delay our ability to provide fully integrated care.

• Number of Performance Indicators: There are a high number of key performance indicators that will require data collection and tracking which will pose a burden on all of our organizations. This will need to be streamlined to be practical.

• Patient Population Characteristics: We have some specific population characteristics and needs that are unique, including having a higher mortality rate per 1,000 people than the Ontario average. Additionally, we have a unique circumstance in that the Eglinton Crosstown will be completed in the coming year and we believe this will change healthcare demand for our OHT.

Legal / Regulatory

• PSLRTA – Having a strong governance structure and tie-ins with each other via integrated programming and staffing may trigger PSLRTA applications from unions, leading to significant challenges in how care is currently provided.

• HCCSA – Without a clear understanding of how existing home care contracts will be managed, there seems to be an undefined interim period of change that will require new processes to be setup and quickly modified to adapt.

• Governance – Developing a governance structure that allows for organizational independence but also creates the synergies required to successfully manage an OHT will take time.

• Access to provincial assets: Service Provider Organizations are currently not approved HICs for LHIN patients, and VHA, SE Health do not currently have access to ConnectingOntario. Additionally, LOFT and SPRINT do not have access to the medications portlet in ConnectingOntario.

• Bed Access: Current legislation allows patients to select up to 5 LTC choices which cause long waits in hospitals. The removal of legislative barriers that challenge moving patients to LTC is recommended.

• BPS Guideline Compliance: We would like to understand the requirements for OHTs to comply with BPS Guidelines and the need to engage in competitive procurement activities, even when working within the confines of the OHT member group.

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

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

Max word count: 1000
The following resources would be beneficial to support the future success of Ontario Health Teams:

Performance & Accountability
- The Ministry of Health's system-level performance metrics for OHTs.
- Information and engagement in the development of future accountability agreements with Ontario Health and OHTs.

Funding & Data
- Additional information/resources on, and opportunities to engage in decision-making as it relates to future funding mechanisms, including single funding envelope, risk and gain sharing, etc.
- Patient record-level data to enable a better understanding of our attributed population.

Strategic
- Information and the path forward for the Government's vision for Provincial Programs (e.g. cardiac care, neurology, etc.) and specialized programs/services that align with the broader goals and vision of OHTs and attributed population methodology.

Digital & Information Technology (IT)
- Implementation of legislative and regulatory changes (e.g. PHIPA) and technological interfaces to enable enhanced and comprehensive information sharing between and among health care organizations, primary care providers, and patients, and data collection to inform quality improvement.
- Information on IT assets that will be leveraged and/or enhanced at the Provincial-level to improve access to sharing clinical information across providers and with patients.

Interoperability of OHTs
- Additional information and guidelines of how OHTs can collaborate together, with special considerations given to overlapping populations and large urban centres.

Legislative & Regulatory
- Information on the implications for OHTs on the following acts:
    - o PSLRTA
    - o Labour Relations Act
    - o Connecting Care Act
    - o PHIPA
    - o HCCSA
    - o Other relevant acts that may impact each service provider organization and/or OHT.

6.6. Risk analysis

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

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

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

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

6.7. Additional comments

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

Max word count: 500

7. Membership Approval

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

By signing this section, you indicate that you have taken appropriate steps to ensure

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

that the content of this application is accurate and complete.

Ontario Health Teams
Full Application Form

APPENDIX A: Home & Community Care

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

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

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

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

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

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

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

Max word count: 1500 Our Vision: Accessible, timely, team-based, integrated, competent and compassionate care for those who need it and that is driven by what matters most to patients, their caregivers and families.

We are committed to ensuring the care experience – the quality, safety and health outcomes that enable people to live as independently as possible at home and in the community – will be at the heart of all we do together. Our vision of a better, modern home and community care system is rooted in what we have heard from patients/families:

- I have simple/easy access to care 24/7 when and where needed - one number and website to access or someone to make that link for me
- It is clear to me what my choices are for care and how much care I will receive
- I have a greater role in self-directing and managing my care at home and more flexibility and choice in designing how the care is delivered in a way that works for me.
- When my care needs are complex, I will have one person whose job it is to help me through all phases of my care
- My care is reliable. I know who is coming and when.
- My caregiver(s) is part of the care team – they are informed, involved, supported (with respite and services as needed to ensure their own health and well-being) and have access to my health record
- I know what to expect when I leave the hospital – who is coming, when, how much care I will get
- I have access 24/7 to the care and support I need

In addition to focusing on what matters most to our patients, we are seeking to implement a delivery model that enhances the experience of all involved patients, and providers alike, that is robust and simple to navigate, and reduces administrative burden and duplication while still ensuring oversight and accountability. Some key elements of our vision are described below and subject to identification of available resources.

Team-based Care
The community-based participants of our OHT propose to be organized and distributed geographically through Neighbourhood Care Teams (locally based care). (Note: specialized care may need other forms of service allocation models based on networked relationships rather than co-location).

Each Neighbourhood Care Team would include the following:
- Primary Care Providers
- In-home Nurses (and nursing clinics)
- In-home Rehab Therapists (and rehab clinics)
- Personal Support Workers
- Community Supports (Social Work, Caregiver Support, Meals-on-Wheels, Transportation, etc.)
- Care coordinators and system navigators (providing intake, information about available services and options, referrals, care coordination, and follow-up, including linking to and coordinating PCPs, specialist care, other clinical services, and social supports).
- Other (e.g. patient accompaniment)

Patients have their choice of PCP. Their PCP may be outside the North Toronto area, in which case care coordinators or system navigators will liaise with and share important information between the PCP and the appropriate Neighbourhood Care Team(s).

All patients would "own" their personal health information (PHI) and provide consent to PCPs, other OHT participants, and family members to access their PHI as needed. Consent will need to be a simplified process without undue burden on clinicians. PCPs and other OHT participants will have access to a shared electronic health record in accordance with our short and long-term digital health record integration plans. As we move forward through the OHT maturity process, secure communications between providers will be enabled.

Access to Care and Service
Subject to identification of available resources, we will aim to have one public number to call to access care. However, the reality is that patients will continue to knock on many doors, and each one must be able to assess and onboard a patient without sending them to yet another entrance way.

When planning possible solutions, we will always ensure to honour our patients' input. As the OHTs roll out in conjunction with changes in legislation and funding models that will enable innovative new practices, we will endeavour to ensure an iterative process for how we manage home and community care.

We are proposing that there are three ways patients will be able to access home healthcare, home support and community care:

1. Referral from a Primary Care Provider (PCP)

The PCP will refer the patient to a designated system navigator, who, jointly with the patient, will do an assessment (using a standardized tool chosen by the OHT or provincially by Ontario Health) to determine the services needed. In the event home care services are needed, the intensity of service will be determined based on need and matched with resources available. Education will be provided to the patient to ensure informed decisions can be made, and that they are comfortable in this capacity. The system navigator will link the patient with a Community Support Agency, based on their preferences and needs, the Agencies in their geography, and Agency capacity. The Agency will alert the PCP that service has begun and ensure the common record is kept up-to-date so the PCP will have that information.

2. Discharge from an acute care institution

On discharge from hospital, the hospital care coordinators / navigators will refer the patient directly to the home care provider and other community services as indicated. Assuming the majority of post-acute patients are on a defined pathway, the provider will have a clear care plan to follow.

3. Self-referral or family referral (directly from the community) to

Home/Community Care:
It is envisioned that each OHT participant organization will have assigned care coordinator(s) to perform the same functions described above for PCP groups.

One Assessment
• A common assessment tool will be in place that considers the holistic needs and well-being of patients including barriers related to social determinants of health.
Care Pathways, Standardized Basket and Intensity of Services
• The OHTs will continue to work on expanding pathways for episodic care and bundled payments for chronic illnesses, co-morbidities and frail/complex seniors.
• Where a pathway does not apply, the basket of services and the intensity of service from community healthcare and support providers will be based on patient needs and determined by a standard guide utilizing evidence-based tools which can readily determine ADL/IADL issues. It will acknowledge the specialized services and associated costs required to support the most complex, particularly those facing housing instability, mental health and addictions.

One Care Plan
• Our care teams will receive the request for service (from patient/hospital/PCP) and develop one comprehensive care plan in collaboration with patients, caregivers, families and care providers considering the needs and the resources currently devoted to such patients.
• As modifications are required, other OHT partners will add to the Care Plan which will have the necessary flexibility to accommodate medical treatments as well as social determinants of health (e.g., housing, 'social prescriptions', etc.)

One Record and One Consent
• There will be a standardized personal health information consent for the OHT, and the patient controls access to the elements of their PHI.
• An electronic record will facilitate information sharing to enable and support communications across the continuum of care.
• Clinical notes will be documented in local Point-of-Care systems used by each participant. The information in those systems will be available for viewing through MyChart (short-term) and ConnectingOntario (long-term)

One Care Coordinator or Clinical System Navigator
• Subject to available resources, embedded in each Neighbourhood Care Team and assigned to PEM groups will be system navigators (non-clinical) who are the first telephone/e-mail contact for patients and who assist patients with information referral support, and link them to other OHT providers.
• When patients' needs are complex the system navigator can link the patient/caregiver with a care coordinator, who can support the patient by coordinating and managing the patient's complex care. The system navigator role overlaps in some instances with the role of Social Workers in the community and further planning around the connection / communication between these providers will be required. Specialized Care Coordination for particular populations will also be explored to

ensure patients are supported equitably by someone who can best meet their need. • Care coordinators are skilled clinicians (e.g. nurses, social workers, OTs) who handle complex cases, coordinating the patient's ongoing, complex, multidisciplinary care provided by multiple providers, and will be the patient's 'guide at their side' for their whole care journey. Each care coordinator will have their own caseload of complex patients. They will have access to the patient's PHI and will be in ongoing contact with the patient, the patient's PCP and the patient's other service providers. Integration, Service Flexibility and Innovation Through changes in legislation and through OHT Participation Agreements, flexible, innovative and efficient patient/family-centred care will be encouraged and supported. • To increase system capacity and respect patient/caregiver schedules and preferences, virtual visits through video and telephone technology will be prioritized. Care pathways will be designed to include virtual visits. • OHT participants/provider-run clinics will be available for use by mobile patients, including nursing, rehabilitation, pain, wellness and mobility clinics. In addition, we envision mobile health clinics that will travel to designated high need communities to reach those who are reluctant/unable to go to a clinic site.

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

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

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

Role/Function	**Organization**	**Delivery Model** (What type of provider (dedicated home care care coordinator, FHT allied health professional, contracted sevice provider nurse, etc) will be providing the service and how (in-person in a hospital, virtually, in the home, etc.)

Managing intake		
Developing clinical treatment/care plans		
Delivering services to patients		
Add functions where relevant		
See supplementary Excel spreadsheet		

Max word count: 1000

In Year 1, our OHT will focus on frail seniors. Our goal is to enable people to live as independently as possible at home and in their community of choice.

We will focus on integrating Primary Care Providers (PCPs) with a robust Neighbourhood Care Team (NCT) of regulated and non-regulated health professionals who offer wraparound services. Additionally, we aim to expand primary care attachment with hospitals to ensure frail seniors not currently connected to a PCP are attached.

Year 1 Home Care Requirement

North Toronto neighbourhoods have a high proportion of seniors living alone. Condo and apartment growth in the region will see more seniors downsizing as a result of age and social circumstance. Based on data provided by the Ministry and knowledge of this region, we anticipate 3,855 patients of our targeted Year 1 population will require one or more home care services.

Seniors often have a low socioeconomic status, are socially isolated, and they can experience complex medical conditions combined with mental health issues.

Our Year 1 population may reside in supportive housing units or seniors' apartments. They will have varying abilities to manage their activities of daily living in their home setting. They may or may not be attached to a family physician and will have current or previous experience with varying types and intensity of home care services.

Year 1 will focus on implementing the NCT model being designed for four high density seniors' supportive housing buildings in the Mount Pleasant East and West Neighbourhoods. Our OHT participants in these neighbourhoods have a history of working together in similar models and are familiar with the needs of the residents of these neighbourhoods.

We will leverage existing assets and relationships and, as implementation progresses, the NCT model will be expanded to seniors living in these and surrounding residential areas. A hub and spoke model of care may be implemented to leverage the supportive housing sites as hubs for the care teams.

The model of a NCT incorporates elements which patients and family caregivers tell us they want, with care and support services that are accessible and available when and where they need them, provided by members of a team that work together, communicate frequently, and provide On-Call services 24/7.

The Mount Pleasant East and West NCT will build on the expertise of community support agencies that know and currently support the residents coupled with the larger team of current LHIN-funded Service Provider Organizations, a collaborative team of primary care providers from the local neighbourhood, the local hospital, local Community Health Centres and Toronto Community Housing.

Managing Intake: Patients and families tell us they want one number to call and/or one website to access. They want a public number that will connect them to a live person, 24/7. Other stakeholders including team members, physicians, hospital referral sources and patients/family members will also have 24/7 access to this number.

For the initial four Seniors' NCT test site buildings, the community support agency staff experienced in intake and care coordination will be embedded in the building to provide easy access to services. Intake and care coordination will commence with any of the NCT organizations who will have intake and care coordination capabilities. The intake function will also include timely referrals to services not within the NCT, such as specialists, dental and optician services, pharmacy, public health, etc.

Intake personnel will begin a Collaborative Care Plan (CCP), the common assessment tool that will connect all members of the NCT with the patient. The intake system navigator will acquire consent for sharing information with the NCT and other OHT participants, complete demographic information, record the patient's identified needs/concerns, and identify and initiate the most appropriate and available referral to the most responsible, lead organization. Additionally, the patient will be attached to a care coordinator, and the PCP will be notified of the referral for services.

Developing Clinical Treatment/Care plans: Utilizing the electronic CCP, the required clinical care and supports will be assessed and will be available in ConnectingOntario and MyChart.

Any college-required regulated health professional clinical assessments will be attached to the EHR. Where best practice guidelines or clinical care pathways are available, those will be used to determine service frequency and intensity.

The NCT team will communicate through and document on a single care plan. The care plan will reflect care and social support needs and patient preferences. Goals of treatment will be co-designed with the patient and/or family caregiver and will be patient driven. The care plan will be updated through collaboration with all members of the NCT and the patient.

Delivering Services to patients: Given this NCT model will be implemented initially in four Seniors Supportive Housing buildings, we will have an opportunity to test a number of different implementations of the care model. Many seniors, due to the nature of their complex care needs and co-morbidities, will require and receive care in their home from current LHIN-funded clinical and/or support service providers.

Others with more mobility could benefit from an on-site integrated nursing and allied health clinic. It could be housed permanently in a seniors' building or be operated as a 'pop-up' clinic, utilizing temporary space in the building and serving residents on certain days. When operational, it will focus on those seniors considered as 'rising risks'. Emerging or declining care needs will be assessed in a multi-disciplinary setting where deteriorating mobility, health or social conditions are identified and addressed in conjunction with the PCP. Referrals can be initiated and the negative consequences of health decline can be avoided or interrupted.

Services can be provided by multiple multi-service organizations to ensure capacity and continuity such as Home Care organizations, inter-professional Primary Care Teams (e.g. Baycrest model), or services from a health centre such as Vibrant Healthcare Alliance.

During surge months, utilizing the transportation services of SPRINT Senior Care, a mobile flu clinic can travel to any location where seniors typically gather within the geography.

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

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

Max word count: 1000

The TC LHIN has been a positive and active participant in our work to date on the development of our OHT. Prior to the MInistry's call for groups interested in becoming an OHT, the TC LHIN collaborated with their partners to explore ways to better integrated services and leverage the assets and functions of the LHIN for the benefit of patient/families/caregivers. As part of that work, there are a number of promising projects underway that we intend to build on in our community (such as Neighborhood Teams; enhancing the coordination role in the hospital, assigning LHIN care coordinators as hospital navigators/care coordinators; and working to eliminate duplication of assessments and non-value added steps from referral through to the delivery of home care services in the community through process mapping exercises). (see Addendum 11, 12 and 13)

It is important to note that any transition of resources needs to be thoughtfully planned and executed in the least disruptive way to patients, families and staff alike. To help us with transition planning, the TC LHIN prepared an inventory of their resources in two groupings:

1) Care Coordination and System Navigation – In a renewed and integrated home and community care system, effective care coordination and system navigation remain key elements of delivering coordinated, patient-centered care and support, particularly for those with complex, unstable physical/mental challenges with limited and/or severely depleted family supports. We envision the transition of care coordination and system navigation resources from the TC LHIN to NT OHT members of our Neighbourhood Care Teams, including community support agencies, home care providers, acute care facilities, and Primary Care Providers (PCPs) to supplement the activities provided by these organizations and take on the care coordination and system navigation roles of the Neighbourhood Care Teams as required and in proportion to the level of care required for our Year 1 target population.

It will be important to have skilled care coordinators and system navigators in the Neighbourhood Care Teams. They will be available to support PCPs and their patients, regardless of the practice model – from FHTs to solo fee-for-service physicians. The first port of call for people looking for help is often their PCP (family doctor, nurse practitioner, etc.). We want to make it effortless for PCPs to link their complex patients to a care coordinator, and all patients to system navigators who can help them access the support and services they need, whether it's a day program or meals on wheels or nursing care in the home, and be the constant "go to" person for the patient and family for care coordination and system navigation purposes.

For patients with acute/episodic or complex/chronic conditions that require hospitalization, we envision the care coordinators / navigators in the hospital will ensure the post-discharge home care pathway is set up and will support the patient until the hand off to the designated home care provider is complete and has assumed full responsibility for the care delivered in the home.

Going forward, LHIN care coordinators would perform navigation services as and where needed to supplement the resources currently available within the NT OHT. They would be attached to any of the home care providers and embedded in Neighbourhood Care Teams so they will have consistent and continuing relationships with our patients/caregiver.

There are also many administrative, non-clinical staff within the LHINs (such as Team Assistants) whose talents could be used to support the Neighbourhood Care Teams. We propose having these knowledgeable non-clinical staff carry out essential system navigation roles.

Current LHIN non-clinical staff and existing staff at community agencies could be system navigators, particularly for patients with less complex conditions and health care needs. Using non-clinical staff in this role has been implemented in other jurisdictions with success, improving health outcomes and lowering costs.

2) Regional Supports – We envision that many of the regional resources, particularly any involved in direct service, be deployed across the OHTs in Toronto – e.g., rapid response nurses, tele-homecare, and palliative care. Home care providers already have robust nursing programs and are well able to engage with these much-needed practitioners, as well as provide the necessary clinical expertise and oversight to ensure on-going competent practice.

With these changes, operational efficiencies will be gained, relieving some of the current strain from our limited resources and improving care experience and outcomes for our patients. Once implemented, a further assessment will need to be performed of continuing gaps in care and the need for additional resources to support the demand.

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

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

Max word count: 1000
Many long-standing legislative/regulatory frameworks, policies, practices, contracts, as well as attitudes have shaped the current approach to home and community care. We have identified several of these perceived barriers to achieving the vision of integrated Ontario Health Teams below. These barriers require thoughtful review and action to support all aspiring OHT teams across the province, as we work together to unlock the potential of home and community care to positively contribute to the quadruple aim objectives.

We appreciate that the government has sought to remove legislative barriers and facilitate integrated care through OHTs by implementing the Connecting Care Act (e.g., allowing non-HSPs, home care agencies, to be full partners in OHTs) and amendments to the Public Sector Labour Relations Transition Act (PSLRTA) (e.g., clarifying that PLSRTA does not apply to OHTs). This legislation is very new, as is the concept of OHTs, and it will be important to see how it is interpreted and upheld, when tested, in the changing context of health sector transformation.

Privacy Legislation and Practices

- Sharing information among the broader care team needs to be made easier under privacy legislation. Although one of the stated purposes of the Personal Health Information Protection Act (PHIPA) is to facilitate health information sharing, health care providers need a better understanding of 'circle of care'. Specifically, the PHIPA needs to be amended to explicitly define all service partners in an OHT as part of the "circle of care" for patients of any member of that Ontario Health Team.

- By the terms of the standard LHIN contract, home care providers are "agents of the LHIN" for privacy purposes rather than Health Information Custodians. Not being a HIC prevents Home Care Agencies from participating in systems of shared health care records (e.g., Connecting Ontario) that support integration efforts, and causes excessive, non-value-add bureaucratic work.

- The Archives and Record-Keeping Act should allow home care providers to follow normal and appropriate record destruction schedules. (Note SPOs were historically doing this until instructed over 2 years ago to stop and await instruction from the LHIN, which to date has not been forthcoming.)

Human Resources

- There is a shortage of human resources to meet patient needs, particularly PSWs who provide most of the home care funded services in Ontario. Supply has not kept up with the demand, resulting in the non-delivery to patients of much-needed care, and overworked and overwhelmed PSWs. As well, OTs and shift nurses are becoming increasingly difficult to recruit and retain in the community sector.

- Historical funding inequities and disparity in working conditions between health care sectors creates barriers to recruitment and retention in home and community care. Wage and benefit discrepancies exacerbate our ability to attract the talent required.

Wage Rates
• Discrepancies in wages among member organizations give rise to concerns respecting labor retention when organizations work together as a “team”. Extending hospital wage rates to community and home care providers would entail major cost escalations for our health system and endanger the sustainability of care services.

Home Care Contracts
• Historical market share contract commitments are not always aligned with geographic regions, neighborhood areas or population needs. This can limit flexibility and nimbleness in responding to shifting needs.
• Onerous contractual obligations, such as multiple reports, add unnecessary non-value add administrative burden and costs.
• Vendor/purchaser relationships and mind-set are antithetical to open, collaborative relationships in an integrated service delivery system.
• Contractual prohibitions in the standard LHIN contracts limit innovation, such as virtual visits and digital/video consultations, as currently only face to face encounters are permitted.
• The standard LHIN template requires duplicative assessments and multiple care plans, using health care providers’ time.

Funding
• Fee for service (by hour/visit) reimbursement not only impacts negatively on the SPO’s ability to recruit, but it limits teamwork and integration activities and erodes team engagement and patient centered care. It limits the participation of some team members in unfunded activities – e.g., care planning and review conferences.

• As well, along with various collective agreements, the lower pay in the home care sector restricts secondments across sectors that would benefit patient care. For example, for some patients (such as children with medical complexities who go in and out of hospital frequently), it would be of benefit for continuity of care and for safety to have the same staff team follow them in and out of hospital.

• Service eligibility and funding allocation formulas at the individual patient level, as well as overall investment in home and community support despite recent increases, are insufficient to support patient choice to remain at home without great personal cost (for those with the financial means) and significant burden and stress on the part of caregivers often negatively impacting their own health and well-being.

Other
• There is a lack of standardization of practices across the LHINs. Each LHIN has its own monitoring and reporting practices, using its own, different forms, resulting in additional time and effort spent training staff to work differently in each LHIN and duplicating work. It will be important to ensure that OHTs don’t re-introduce this lack of standardization into the system. Many home care and community support

organizations work in more than one OHT. Ideally, common assessment tools, common forms, and common digital health policies and practices will be adopted across all OHTs. In addition, patients/families should not see or feel a difference in process from one OHT to the next.

- There is a lack of real-time access to complete health care records, assessment, and service/care plan information by both the patient/family and the care team.

APPENDIX B: Digital Health

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

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

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

B.1 Current State Assessment

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

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

B.2 Digital Health Plans

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

2.1 Virtual Care

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

Max word count: 1000

Virtual care is defined by the Digital Playbook as video visits, audio calls, and secure messaging. In the NT OHT, the majority of our partners are currently providing one or more of these virtual services.

In the near-term, the NT OHT partners will continue to leverage and provide the virtual care services using the tools and solutions that are already in place. In the future state, it is the NT OHT's goal to align to a single virtual care platform and standard for all our patients.

To describe the future-state NT OHT vision for virtual care, providers will log into their local point-of-care applications and launch a virtual care viewer that is integrated to access data and functions from their local systems (such as lab results and documentation tools). The virtual care integrated viewer reduces the need for duplicate documentation and eliminates navigating between the virtual care application and the local point-of-care application. For patients, the virtual care application will be able to be integrated with the MyChart patient access channel. From MyChart, the patient will be able to conduct the virtual visit session with their provider and also review notes and document within their own personal health record. Please see Addendum 14 for an overview of the future-state Virtual Care Integrated Viewer.

In terms of measuring success of virtual care, the NT OHT digital group will work closely with our clinical operations team as clinical pathways and focuses are finalized (potential examples include ED admission rates post-virtual care follow-ups, patient satisfaction, etc.). Furthermore, for measurement of virtual visit volumes, the NT OHT is engaging with OTN to identify opportunities for more granular reporting to help support potential measures of success.

Based on the data on volumes in FY18/19, the NT OHT is confident we will be able to achieve our virtual care visit targets for the Year 1 patients attributed to our region. For partners that do not offer virtual care services, we will work collaboratively to develop and implement virtual care offerings aligned to our OHT clinical pathways by sharing our expertise, tools, and lessons learned. Below is a summary of the virtual care offerings and volumes by NT OHT partner site.

Baycrest
- Virtual Care Services Offered
    - Geriatric assessment clinic
    - ICCT (integrated community care team)
    - IPCT (interprofessional primary care team)
    - LSVT (lee silverman voice treatment - lsvt® loud clinic)
    - Memory clinic
    - Seniors counselling and referral
    - Telepsychiatry service
    - Virtual home assessment
    - Virtual Palliative Care Consult to Long-Term Care
    - Virtual Consults through Ontario Telemedicine Network (OTN)
- Virtual Visit Volumes in FY18/19
    - Geriatric assessment clinic: 2 (OTN)
    - Telepsychiatry service: 2,828 (Meditech, GPCS telephone visits)
    - IPCT: 23 (virtual and telephone visits)
    - ICCT: 7 (telephone visits)
    - OTN mental health (telepsychiatry): 1,598
    - OTN others: 214

LOFT Community Services
- Virtual Care Services Offered
    - Virtual Consults through Ontario Telemedicine Network (OTN)ICCT (integrated community care team)

- Virtual Visit Volumes in FY18/19
  - OTN encounters: 34

SE Health
- Virtual Care Services Offered
  - Virtual Visits through Medocity
  - 24/7 Nurse support through CPRT
  - Elizz caregiver support
  - Telephone consults
- Virtual Visit Volumes in FY18/19
  - Virtual Visits, telephone, and secure messaging: 5,000 (for Toronto region)

SPRINT Senior Care
- Virtual Care Services Offered
  - Virtual Consults through Ontario Telemedicine Network (OTN)
- Virtual Visit Volumes in FY18/19
  - N/A- implemented in FY 19/20

Sunnybrook Health Sciences Centre
- Virtual Care Services Offered
  - Virtual Consults through Ontario Telemedicine Network (OTN)
  - eVisits
  - Telephone advice consults
- Virtual Visit Volumes in FY18/19
  - OTN encounters: 3,749 (across Ontario)
  - Telephone advice consults: 2,049 (across Ontario)

Unison
- Virtual Care Services Offered
  - n/a
- Virtual Visit Volumes in FY18/19
  - n/a

VHA Home Healthcare

- Virtual Care Services Offered
  - Telephone consults
  - Virtual consults through Pixalere
  - Secure Messaging
- Virtual Visit Volumes in FY18/19
  - Virtual visits: 498 (for patients in North Toronto)

Vibrant Healthcare Alliance

- Virtual Care Services Offered
  - Virtual Consults through Ontario Telemedicine Network (OTN)
  - Telephone consults
- Virtual Visit Volumes in FY18/19
  - Direct individual telephone consults: 2,688
  - Third-party telephone encounters: 1,689
  - OTN encounters: 27

Toronto Central LHIN

- Virtual Care Services Offered
  - Virtual Consults through Ontario Telemedicine Network (OTN)
- Virtual Visit Volumes in FY18/19
  - OTN encounters: 9
  - Patients enrolled in Telehomecare: 559

Primary Care

- TBD Primary Care to be on-boarded

2.2 Digital Access to Health Information

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

Max word count: 1000

In alignment with the TC LHIN Citizen's Panel Digital Health Working Group, the NT OHT is committed to ensuring equal access to real-time health information to all parties involved in the circle of care, including patients, caregivers, and substitute decision-makers.

The NT OHT will leverage the MyChart patient access channel to provide digital access to information for patients. MyChart is a patient access channel developed by Sunnybrook Health Sciences Centre that streamlines the way health record information is accessed and shared by patients and their delegates. The MyChart patient access channel is currently used by 546,000 patients across Canada.

With the MyChart patient access channel, patients are key stakeholders in the delivery of care and MyChart empowers them to manage their health through access and contribution to their personal health information and the ability to securely communicate with other users (e.g. family, friends, healthcare providers). Electronic access to PHI can be granted by patients to family caregivers, hospital clinicians, primary care physicians, home and community care staff, pharmacists, and others. The MyChart patient access channel also has an architecture that supports Application Program Interfaces (APIs), allowing other technology platforms to connect, tap into and share information to support patient care.

In the NT OHT, integration with the MyChart patient access channel is in-place or planned to move forward with the majority of partners. The goal of the MyChart patient access channel is to have all partners develop interfaces from their point-of-care systems to share data with our patients. The status of each partner is noted below.

- Live on MyChart
  - Sunnybrook and Baycrest
- Technical planning underway
  - SPRINT, OLIS, LHIN CHRIS
- Integration discussions underway
  - LOFT, VHA, SE Health
- TBD
  - Vibrant, Unison, Primary Care

- o Primary care and CHC (Vibrant and Unison) integration is TBD due to the primary care EMR integration challenge noted in section 4.3.1.

The future state vision of the MyChart patient access channel in the NT OHT is depicted on Addendum 15. MyChart will be the central aggregation point of data for our patients with integrations with community care, acute care, primary care, specialist care, and provincial assets.

Based on the target population of the NT OHT, we are confident we will be able to reach the 2-5% Year 1 targets. Using postal codes as a proxy of patient attribution, the MyChart patient access channel has 6,769 enrolled patients who are 65+ with North Toronto postal codes, which represents approximately 19% of the NT OHT population that are 65+. Of those enrolled patients within North Toronto postal codes, 3,235 were active in the last 12 months (as of August 2019).

2.3 Digitally Enabled Information Sharing

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

Max word count: 1000

As discussed in 4.3.1, the NT OHT information sharing strategy is based on ConnectingOntario and MyChart (near-term solutions) and FHIR integration (long-term solution). Through data sharing, care planning and delivery can be coordinated across partners throughout transitions of care.

To further illustrate how our proposed digital solutions work together to enable integrated care delivery and planning, the NT OHT digital team has applied our near-term and future state solutions for digital information sharing to use-cases below.

Use Case 1: Emergency Department encounter and follow-up

A 75-year-old arrives at the Sunnybrook Emergency Department needing help. Her condition has worsened in the last 72 hours. Based on the NT OHT rostering criteria, the patient is identified as a NT OHT patient. Subsequently, all circle of care providers are notified of her visit through BetterCare (near-term solution) or ConnectingOntario (future state solution). For her current visit, the ED doctor assessment findings are documented in the EMR (SunnyCare).

In the short-term (Year 1), all information from the encounter at Sunnybrook is available in the MyChart Provider Portal to OHT partners based on implied patient consent. Additionally, data will also be available through regional/provincial resources such as ConnectingOntario.

In the long term (Years 2-5), through FHIR, the information documented by the ED provider in SunnyCare will be available to all OHT partners to see in their local EMRs.

Once home, the patient (and family) log into the MyChart patient access channel and see appointments, notes, test results, medications, care plans, and any follow-up information. They are also able to get caregiver support through apps such as Elizz.

This workflow for digital information sharing will enable continuity of care amongst all providers to develop a coordinated care plan. Coordination and continuity of care could be further enabled through virtual care for follow-up visits.

Use Case 2: Family Physician information sharing with the Baycrest IPCT (Interprofessional Primary Care Team)

A family physician is sharing care of a patient with the Baycrest IPCT. The family physician will know the IPCT clinician is able to access the medical history of the patient whenever they need through the NT OHT shared record solutions of the MyChart Provider Portal/ConnectingOntario (near-term solutions) and FHIR integrated systems (future-state solution).

With the identification/notification features of BetterCare (near-term solution), and ConnectingOntario in the future (pending enhancements), the family physician is notified of the patient’s encounters with the Baycrest IPCT clinicians. The family physician will be engaged appropriately when needed, and when the family physician connects with the patient next, they will know what is going on with the patient through access to NT OHT shared record solutions of MyChart Provider Portal/ConnectingOntario (short-term solutions) and FHIR integrated systems (future-state solution).

In the future, through an integrated virtual care viewer, the family physician will be able to have digital “hallway consults” with the IPCT clinicians and receive communications from the responsible IPCT clinician without leaving their EMR.

Use Case 3: Patient and caregiver involvement in care planning and management

In the future state, a 70 year old diabetes patient (who is attributed in the NT OHT) and his caregiver are following a care plan developed by his providers. The care plan involves the patient using a blood glucose meter at home and monitoring progress. Through the MyChart patient access channel, the patient is able to self-enter the glucose meter results into their account and is able to share that information with the providers in the circle of care.

At the next scheduled check-up with their Family Physician, the patient's MyChart information is accessible for review (based on patient consent) and the Family Physician is able to identify how the patient is managing his condition.

The Family Physician makes follow-up notes in their EMR and recommends the patient see a diabetes counselor at Vibrant Healthcare Alliance to develop appropriate exercise plans and further nutritional counseling. To enable continuity of care, the Family Physician notes are available for view by providers through the MyChart Provider Portal. Based on the counselor's review of the MyChart information, an exercise plan and diet plan is developed for the patient to follow.

2.4 Digitally Enabled Quality Improvement

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

Max word count: 500

Our OHT is inventorying the partners' digital tools for driving quality of care and performance improvement with a view to identifying opportunities for broader application across the health team and leveraging these capabilities to greater effect. Examples of NT OHT partners using digital tools to improve quality of care for our patients is noted below.

(1) Emergency Department Diversion
• LOFT: EMS QI project: Reduced patients' avoidable ED visits from 32% to 11% through electronic incident alerts
• Sunnybrook- ENCOMPASS-ED: Reduced ED visits from high-frequency patients by 38-53%. Average length of stay of these patients reduced by 30%. 91% of these patients showed a reduction in ED visits.

(2) Improved Patient Experience Initiatives
• SPRINT: Activity PRO and TripSpark Transportation Technology Enhancement: Records quality of engagement from patients (Activity PRO) and allows patients to book/schedule transportation electronically and receive notifications (TripSpark).
• Baycrest: Patient & family involvement in decisions about care and treatment - new initiatives:
    - Interprofessional Primary Care Team (IPCT)

- Interprofessional Community Care Team (ICCT)
- MyChart
- Baycrest@Home EMR
- Memory Care EMR tools

(3) Improved Patient Care Initiatives
• SPRINT, SE Health- RAI assessments (electronic): The interRAI tools include rigorous, evidence-based, standardized, holistic assessments, algorithms for calculating patient and caregiver risk and beneficial care pathways, and outcome measurement indicators at the patient, program, organization and system levels. The tools are embedded in provider-facing platforms as key decision support tools to provide practical support to frontline staff while generating an extensive pool of data for quality improvement and care enhancements.

• Sunnybrook: SunnyCare Electronic Medical Reconciliation (eMedRec): Prompts physicians electronically at admission, discharge, and transfer to complete medication reconciliationelectronically. Ensures all clinicians across transitions of care are kept up-to-date with the latest and most accurate medication information

• Baycrest, Sunnybrook: Timely Discharge Summary Distribution: Electronic tools to distribute discharge summaries (autofaxing and HRM)

• Baycrest: Assessment and Identification of Patients Requiring Palliative Care using the Think Research Clinical Support Tools for Palliative Care Assessment integrated through Point Click Care

(4) Improved Patient Safety
• Baycrest, SE Health and Sunnybrook: Implementation of risk reporting tools to keep our workplace safe by allowing employees to self-report any adverse events and potential risk issues. Using these risk-management tools, the NT OHT partners are able to conduct proactive risk mitigation

(5) Pro-Active Business Intelligence Reporting and Analysis
• SE Health: Connected Employee Base: All front-line staff (nurses and personal support workers) have a smartphone that they use to check-in and confirm patient visits. Data is then automatically used for both visit verification and to feed into an analysis engine that looks at scheduling trends and enables improvements in overall scheduling
• SPRINT Senior Care: CIMS Schedule Mobile App: PSWs have a smartphone that they use to check-in and confirm

patient visits. They also have access to patient information and Care Plan details.

• Sunnybrook and Baycrest: Information Management Dashboards and Reporting Sunnybrook and Baycrest have created dashboards for discharge summary completion and occupancy dashboards which are distributed to senior administration and medical leaders to improve care, utilization, and performance

2.5 Other digital health plans

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

Max word count: 500

In addition to the NT OHT digital health plans mentioned earlier in the application, the NT OHT partners also have the following digital initiatives planned or underway:

SE Health

• Elizz: A lifestyle destination that inspires daughters and sons to live well while caring for their aging parents. Through thoughtful content, Elizz provides resources to help with caregiving, inspirations to practice self-care, and connection with others going through similar journeys.
• EHR Implementation: SE Health has started to launch the first phase of our EHR for personal support workers (PSWs) where all note-taking for PSWs will be done using smartphones, enabling better collaboration among PSWs and enabling supervisors to remotely view how the visit went rather than going in person. We are targeted to rollout EHR for nursing later this year as well.

Baycrest

• Artificial Intelligence tools which close the gap across traditionally separated disciplines and between disparate systems, bringing previously unknown information to light for the benefit of patient care and safety.
• Intelligent Robotic Process Automation
• Expansion of Cloud Computing platform
• Development of standardized framework which harmonizes the co-existence of technological innovation with regulatory compliance
• Continued growth of information privacy and security methodology, process and procedures which support the

above emerging trends and can be leveraged/shared amongst partners

SPRINT Senior Care

- Client Information Management System (CIMS) replacement: SPRINT Senior Care has issued a RFP to replace their CIMS software

Sunnybrook Health Sciences Centre

- SunnyCare development and implementation: Sunnybrook's self-developed EMR, SunnyCare, is in the final stages of development for its computerized physician order entry (CPOE) product with implementation planning underway.
  - Further development of an Interprofessional clinical documentation tool and closed-loop electronic medical administration record (eMAR) is also planned and underway

Unison and Vibrant Healthcare Alliance

- Nightingale on Demand (NOD) EMR replacement: Vibrant and Unison are implementing TELUS Practice Solutions EMR to replace NOD as their EMR

VHA Home HealthCare

- EMR Implementation
  - VHA was Ontario's first LHIN-contracted home care provider to fully digitize patient charts within its nursing practice through the implementation of an EMR. All VHA nurses document at the point of care using tablets. VHA has since extended its EMR into its Rehab practice. All Occupation Therapists now chart electronically. VHA's Physiotherapy practice is scheduled to go-live in November 2019.
  - VHA's EMR is fully integrated with CHRIS. VHA contributes data to CHRIS via the Automated Provider Ordering (APO) and Automated Provider Reporting (APR) Application Program Interfaces (APIs) with many LHIN partners. VHA is currently in discussions with the Toronto Central LHIN on implementing APO/APR which would enable electronic data exchange for NT OHT patients.

LOFT Community Services

- Mobile Patient Documentation Application: A vendor-neutral mobile patient documentation app is being developed to support mobile workforce with simpler, more efficient patient documentation, to maximize the time spent with patients

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

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

Name:	Sam Marafioti
Title & Organization:	Vice President, Corporate Strategy and Development, CIO Sunnybrook Health Sciences Centre
Email:	Sam.Marafioti@sunnybrook.ca
Phone:	416-480-4127

7. Membership Approval

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

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

Team Member	
Name	William E. Reichman
Position	President and Chief Executive Officer
Organization (where applicable)	Baycrest Hospital
Signature	
Date	October 3, 2019

Team Member	
Name	Dale Lastman
Position	Board Chair
Organization (where applicable)	Baycrest Hospital
Signature	
Date	October 3, 2019

Team Member	
Name	James Anok
Position	Board Chair
Organization (where applicable)	LOFT Community Services
Signature	
Date	Oct 2, 2019

Team Member	
Name	Heather McDonald
Position	CEO
Organization (where applicable)	LOFT Community Services
Signature	Heather McDonald
Date	Oct 2, 2019

Ontario Health Team Full Application – Supplementary Membership Approval Sheet

Team Member	
Name	Shirlee Sharkey
Position	Director
Organization (where applicable)	SE Health
Signature	
Date	October 4th, 2019

Team Member	
Name	Stacy Landau
Position	CEO
Organization (where applicable)	SPRINT Senior Care
Signature	
Date	September 27, 2019

Team Member	
Name	Barry Yontef
Position	Board Chair
Organization (where applicable)	SPRINT Senior Care
Signature	
Date	September 27, 2019

Team Member	
Name	Andy Smith
Position	President & Chief Executive Officer
Organization (where applicable)	Sunnybrook Health Sciences Centre
Signature	
Date	Oct 7th, 2019

Team Member	
Name	Tom Flynn
Position	Board Chair
Organization (where applicable)	Sunnybrook Health Sciences Centre
Signature	
Date	Oct 7th, 2019

Ontario Health Team Full Application – Supplementary Membership Approval Sheet

Team Member	
Name	Laurelle Knox
Position	Board Chair
Organization (where applicable)	Unison Health and Community Services
Signature	Laurelle Knox
Date	September 25, 2019

Team Member	
Name	Michelle Joseph
Position	CEO
Organization (where applicable)	Unison
Signature	Michelle Joseph
Date	Sept. 25, 2019

Team Member	
Name	Karen N. Singh
Position	Board Chair
Organization (where applicable)	VHA Home HealthCare
Signature	Karen N. Singh
Date	October 4, 2019

Team Member	
Name	Carol Annett
Position	President & CEO
Organization (where applicable)	VHA Home HealthCare
Signature	Carol Annett
Date	October 4, 2019

Team Member	
Name	Simone Atungo
Position	Chief Executive Officer
Organization (where applicable)	Vibrant Healthcare Alliance
Signature	Simone Atungo
Date	October 1, 2019

Team Member	
Name	Sue Cooper
Position	Chair, Board of Directors
Organization (where applicable)	Vibrant Healthcare Alliance
Signature	S. Cooper
Date	October 1, 2019

Ontario Health Team Full Application – Supplementary Membership Approval Sheet

Team Member	
Name	Leslie Milrod
Position	Patient Representative
Organization (where applicable)	TC LHIN PFAC
Signature	Leslie Milrod
Date	October 2, 2019

Team Member	
Name	Yoel Abells
Position	NT primary care lead
Organization (where applicable)	
Signature	[signature]
Date	27/9/2019

Team Member	
Name	Dr. Jocelyn Charles
Position	North Toronto Primary Care Co-Lead
Organization (where applicable)	Sunnybrook Academic Family Health Team
Signature	[signature]
Date	Oct 3/19

Team Member	
Name	Dr. Karen Fleming.
Position	Chief, Department of Family & Community Medicine
Organization (where applicable)	Sunnybrook Health Sciences Centre.
Signature	[signature]
Date	October 3 2019.

Please repeat signature lines as necessary

Toronto Central **LHIN**

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Toll Free: 1-866-243-0061
www.torontocentrallhin.on.ca

October 4, 2019

The Honourable Christine Elliott, M.P.P.
Deputy Premier and Minister of Health
777 Bay St. 5th Floor
Toronto, ON M7A 2J3

Dear Minister Elliott,

We are writing this letter in support of the North Toronto Ontario Health Team (NT OHT) full application. The Toronto Central LHIN has been actively contributing to the NT OHT and supports their vision and principles to integrate care for patients and caregivers.

The Toronto Central LHIN has participated at many levels in the engagement and planning activities of the NT OHT in their work to become one of the province's first Ontario Health Teams. We have shared feedback and learnings from our patient and family engagement activities around opportunities for system improvements, and have provided support to their leadership in data analytics and digital health. We assisted the NT OHT to gain a better understanding around care coordination functions and opportunities for exploring new ways of delivering care, and I have been a regular participant at the NT OHT executive leadership table. We are confident that the NT OHT are committed to building an integrated system that delivers patient-centred care for the population of North Toronto.

The NT OHT team has developed a comprehensive strategy for meaningful engagement with patients, caregivers and community stakeholders. Leaders and staff within the Toronto Central LHIN have had the opportunity to participate in system planning initiatives and co-design sessions through value stream mapping activities in support of the OHT application process. These opportunities for engagement have allowed the voices of the patients we serve to inform the application and directly influence the planning for the future state of care in North Toronto.

We are confident that NT OHT will continue to meaningfully engage all partners in North Toronto and the application from NT OHT has our support. We look forward to continuing to work with NT OHT in the months ahead to help transition clients to integrated care models to enable high quality patient-centred care for patients and caregivers in North Toronto.

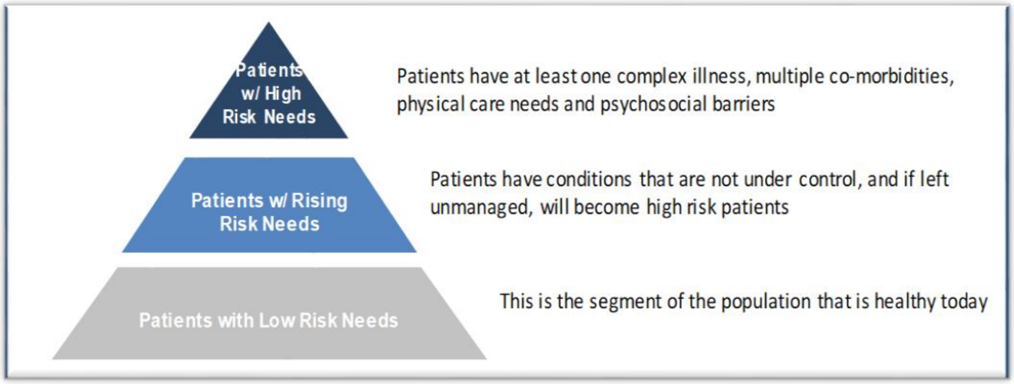
Sincerely,

Tess Romain
Interim CEO

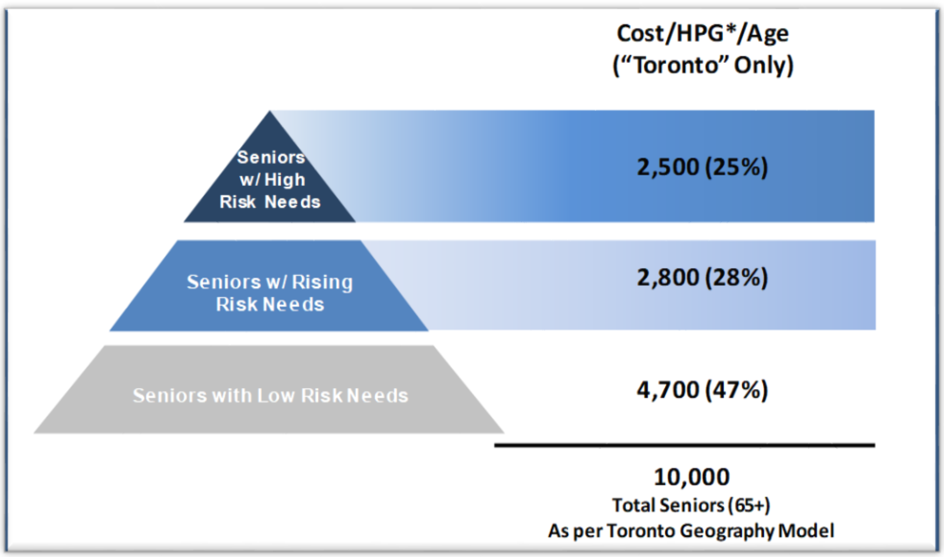
Cc: Phil Graham, Executive Lead, Ontario Health Teams, Ministry of Health
Susan Fitzpatrick, Interim CEO, Ontario Health

Ontario

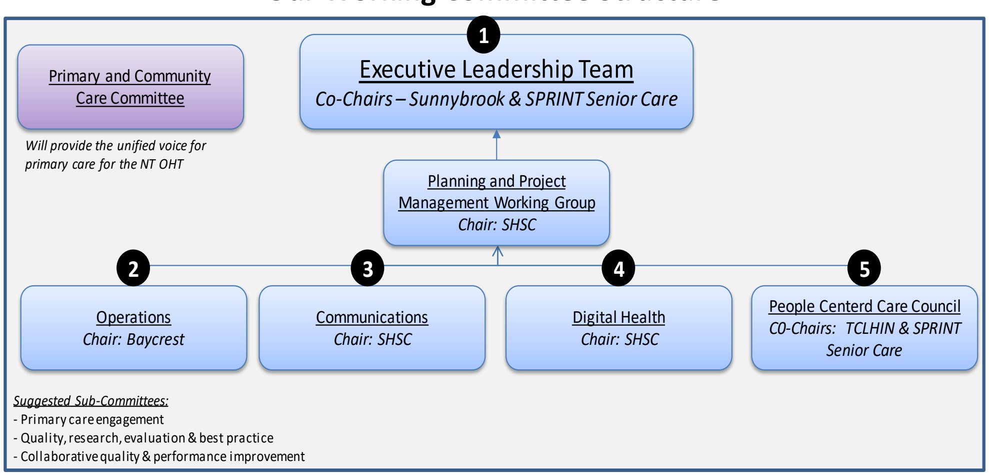
Addendum 1:
Our approach to population health management



Addendum 2:
Our Year 1 Population



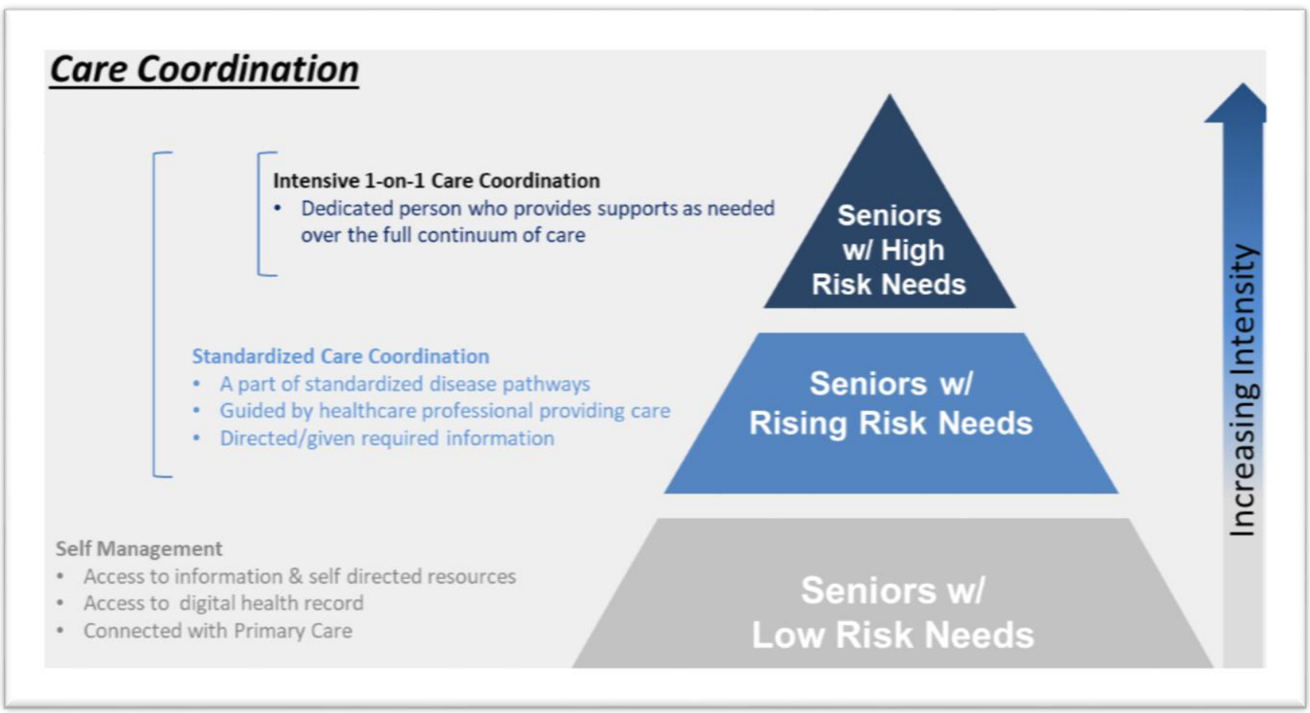
Addendum 3:
Our Working Committee Structure



Addendum 4:
Our Performance Management Approach & Alignment with the Quadruple Aim

Year 1	Metric	Alignment with Quadruple Aim			
		Patient Experience	Provider Experience	Outcome	Value / Cost
High Risk Needs	Increase # of seniors actively attached to care coordinator	✓	✓	✓	✓
	Increase # of seniors attached to homebound primary care	✓	✓	✓	✓
	High patient feedback scores	✓			
Rising Risk Needs	Reduce CTAS III – V visits by Seniors	✓	✓		✓
	Increase physician attachment to SCOPE / TIP / SPIN	✓	✓	✓	✓
	Increase % of seniors that have access to interprofessional primary care team	✓	✓	✓	✓
Low Risk Needs	Increase % of seniors with a virtual health care encounter in the last 12 Months	✓			✓
	Increase % of seniors with access to digital health record	✓		✓	✓

Addendum 5:
Our proposed system of care coordination and levels of intensity

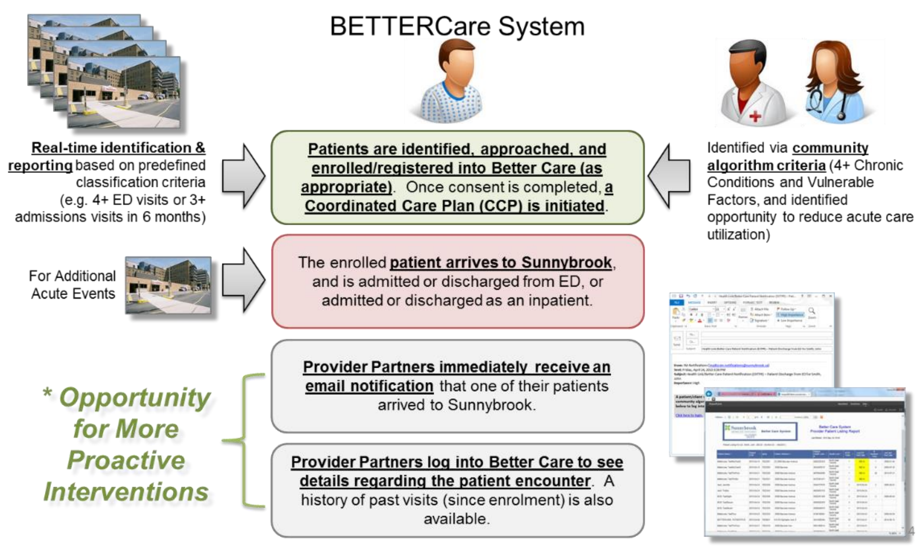


Addendum 6:

Identification and Tracking through ConnectingOntario (future state solution)

Addendum 7:

BetterCare Overview



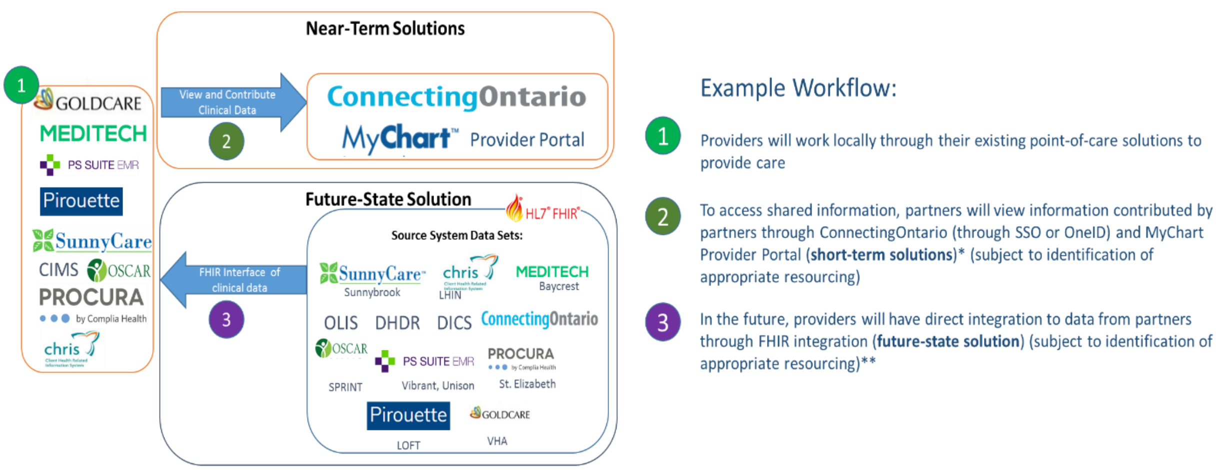
Addendum 8:

Identification and Tracking through BetterCare (near-term solution)

Addendum 9:
Our alignment with the OHT Model Components

#	North Toronto OHT Goal	Ministry defined OHT Model Component
1	Every person is able to access and navigate health care in North Toronto	#1 Defined Patient Population #4 Patient Care & Experience
2	Every person will have access to primary and team-based care when needed	#1 Defined Patient Population #2 In Scope Services
3	People will be engaged as health care partners and both patients and providers will be satisfied with the care coordination available to them	#2 In Scope Services #3 Patient Partnership and Community Engagement #4 Patient Care & Experience
4	Leadership and governance model will reflect shared accountability and collaboration across primary care, community-based care, and hospital care	#6: Leadership, Accountability, and Governance
5	Providers will be jointly committed to continuous improvement and connecting with social services	#8: Performance Measurement, Quality Improvement, & Continuous Learning
6	Performance measures will reflect population health status and health equity; reflect individual and community experience; track value; and show improvement in what we do	#4 Patient Care & Experience #6: Performance Measurement, Quality Improvement, & Continuous Learning
7	Investment will be targeted to meeting need	#7: Funding and Incentive structure
8	Every health care provider will be connected as part of one system of care, including primary care	#5: Digital Health

Addendum 10:
Information Sharing through ConnectingOntario/MyChart Provider Portal (near-term solution) and FHIR (future-state solution)



* Dependent on all partners contributing local EMR data to ConnectingOntario CDR
** Dependent on FHIR and API capabilities of local EMR vendors

Addendum 11:
North Toronto Home and Community Care Service Allocation (TC LHIN data FY 17/18)

Service	Total Number of Patients	Total Units of Service
Personal Support	3,060	579,505
Respite	47	5,931

Lab	213	854
Nurse Practitioner*	44	460
Nursing	2,664	108,477
Nutrition	206	578
Occupational Therapy	2,474	8,478
Psychology**	9	391
Physiotherapy	1,613	12,896
Speech Language	423	899
Social Work	148	408
Grand Total	**10,910**	**718,877**

*Nurse Practitioner is an internal resource of the Toronto Central LHIN

**Psychology is no longer provided through Home and Community Care. This creates a gap in the provision of essential mental health care.

Addendum 12:

Overview of Regional Based Toronto Central LHIN Programs

Program Name	Program Description
Integrated Palliative Care Program	The Integrated Palliative Care Team supports palliative patients and their families: • Relief from suffering, treatment for pain and distressing symptoms • Support for families/caregivers to help reduce caregiver burden • Support to reduce ER visits, crisis 911 calls and hospitalization • Support to die at home or live at home as long as possible • Support to transition to Palliative Care Unit and residential hospices • Support for transition in the finals hours and bereavement support 24hr/7 day week availability Palliative Services include: • Professional Services (nursing, personal support, occupational therapy, physiotherapy, nutrition, social work, speech language pathology) • Equipment, supplies, transportation • Care coordination and health system navigation
Child and Family	The Child and Family Team works with children from birth to 18 or 21 years of age who require a variety of health-related services in home, school and hospitals.
Mental Health and Addiction School Nursing	The Mental Health and Addiction Nurses support Toronto's four District School Boards to recognize and respond to student mental health and addiction issues. The Nurses work as part of the District School Board inter-disciplinary team by providing advice, consultation, and education, and facilitate referrals for students identified with mental health and addictions issues
Rapid Response Nursing	Rapid Response Nurses (RRN) provide in-home nursing assessments for high need, high risk and complex clients within 24-48 hours of discharge from an inpatients unit or the emergency department
Telehomecare	Registered Nurse Coordinators link patients with Chronic Diseases (CHF and COPD) through telehomecare. They provide remote monitoring and regular health coaching sessions, engaging patients in their own care and helping to build healthy self-management skills. They also build and foster relationships with health care providers through integrated care plans and ongoing collaboration with primary care.

Nurse Practitioner	Nurse Practitioners perform comprehensive health assessments, order diagnostic tests and have prescriptive authority for medications. The Toronto Central LHIN provides NP support in the following programs: • Palliative Care, Primary Care, Vent
Pharmacist	The Toronto Central LHIN Pharmacist is a consult-based intervention that is assessed by the Care Coordinator based on need. Patients appropriate for this program are patients with medication related risks that have not been met by the community pharmacist, and the client is unable to access the community pharmacist.
Care Connectors	The Care Connectors connect people who do not have a primary health care provider to a family physician or nurse practitioner in their community. This is accomplished through relationship building and networking with local primary care providers. Health Care Connect is a provincial program.
Intake and Access	The Intake and Access team is comprised of Care Coordinators and Team Assistants who work with referrals from both Community and Hospital setting. The team assesses, prioritizes and completes referral based on need, to ensure timely, high quality access to services.
Information and Referral	The Information and referral team assistance answer questions and respond to request from the public, patients, Toronto Central LHIN staff, services providers and the healthcare community. The team is responsible for triaging urgent issues and new referrals for immediate Care Coordinator response.
Placement Services	**Short Stay Respite** - This program is intended to provide relief to caregivers by allowing clients temporary access to beds in a long-term care facility. This is a paid service, as of July 2018 that cost is $39.34 per day. **Convalescent Care** - a short stay program designed for clients in the community or hospital who are recovering from an acute episode and may require goal-oriented, time-limited care to complete their restorative process in order to remain in the community. **Long Term Care -** Provides care and services for people who no longer are able to live independently or who require onsite nursing care, 24-hour supervision or personal support. The Toronto Central LHIN Care Coordinator completes determination of both capacity for decision- making and eligibility into Long Term Care.

Addendum 13:

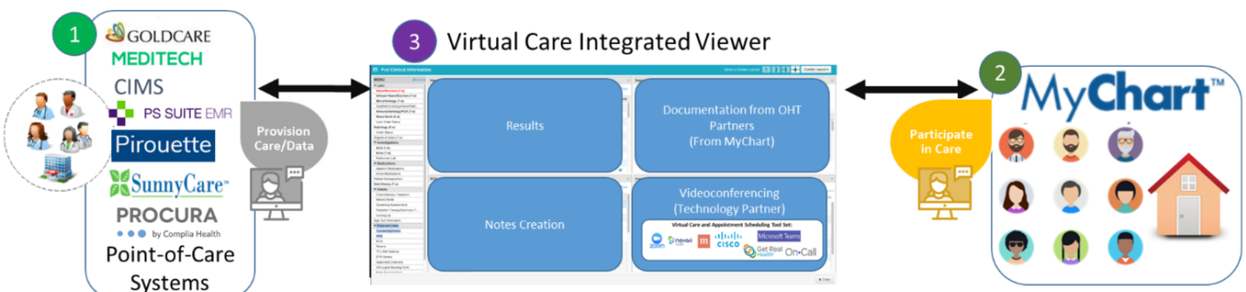
Overview of Services Provider Organizations within North Toronto

Service	**Service Providers**
Personal Support	VHA
	Circle of Care
	CBI Home Health
	SE Health
	S.R.T. Med Staff
	Spectrum
	Bayshore Health Care
	ParaMed
Nursing	SE Health
	ParaMed
	VHA
	Spectrum

	S.R.T. Med Staff
Nursing Clinic	Closing the Gap (York Mills Clinic)
	VHA (Eglinton Clinic)
Occupational Therapy	VHA
	ParaMed Home Health Care
Physiotherapy (Visiting)	Closing the Gap
	VHA
	Spectrum Health Care
Social Work/Speech Language Pathology*	Closing the Gap
	VHA
Dietician	VHA

* Services combined as low service volumes and same providers for each service

Addendum 14:
Virtual Care Integrated Viewer (future-state solution)



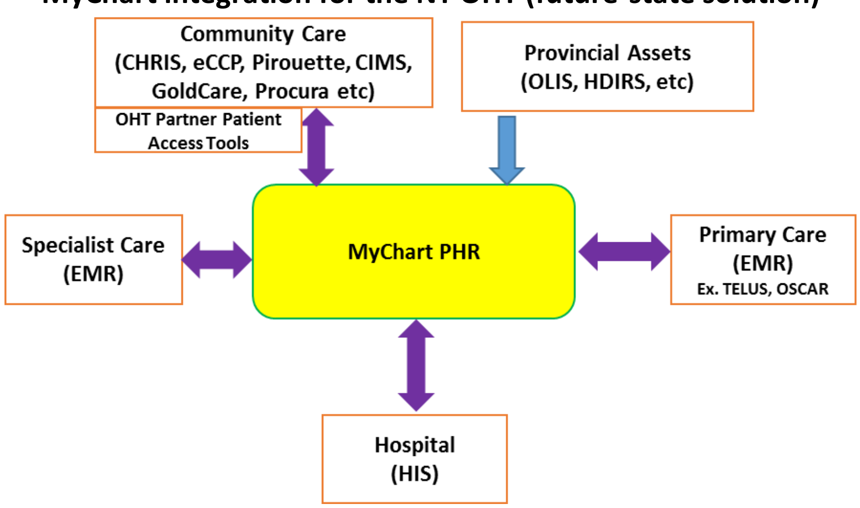
1 Provider logs onto their Point-of-Care System and launches the Provider Virtual Care Integrated Viewer (via embedded link)

2 Patient logs onto MyChart and launches the Patient Virtual Care Integrated Viewer

3 Patients and Providers are able to engage in a virtual visit and review/document information simultaneously through multi-views in the integrated viewers. The notes the provider documents during the session are sent back to their Point-of-Care System and shared with the patient via MyChart feed. The notes the patient documents during the session are saved directly into the patients' MyChart personal health record

Benefit: Integrated virtual visit workflow across the continuum of care that eliminates duplicate screens, windows, and duplicate documentation

Addendum 15:
MyChart integration for the NT OHT (future-state solution)



Sunnybrook
HEALTH SCIENCES CENTRE

DEPARTMENT OF FAMILY & COMMUNITY MEDICINE
Sunnybrook Health Sciences Centre
2075 Bayview Ave. #A120
Toronto, ON M4N 3M5
Phone: (416) 480-4585
Fax: (416) 480-5774

October 1st, 2019

Dear North Toronto Ontario Health Team,

On behalf of the Department of Family and Community Medicine at Sunnybrook Health Sciences Centre which provides care across our community, this letter is to extend our ongoing support for the work of the North Toronto OHT partners to develop an integrated care delivery system and to create a new vision for health care centers around patients, families and caregivers. Our faculty provide primary care across the lifespan including palliative care, long term care, hospitalist care, prenatal care and community-based care and support integration across the hospital and community.

The North Toronto OHT represents the full continuum of care, and brings a commitment to engage all relevant stakeholders, including patient representatives and primary care providers, to co-design an integrated system to serve individuals living in the community and seeking care in North Toronto. The partners of the North Toronto OHT have shown a strong sense of collaboration, working together to ensure connected care for patients that we serve.

Through partnership projects in the past, the North Toronto OHT partners have demonstrated a track record of successful and innovative partnership initiatives focusing on the needs of patients, with a strong foundation to build upon for the transformation to come.

As the Chief of the Department of Family and Community Medicine at Sunnybrook Health Sciences Centre, we will continue to fully support the North Toronto Ontario Health Team, and are committed to working collaboratively with the OHT to support access to care and services. We look forward to being a part of a connected health care system, one that is easy and seamless for patients and families to navigate.

Sincerely,

____

Karen Fleming MD MSc CCFP
Chief, Department of Family and Community Medicine
Sunnybrook Health Science Centre

Letter of Support from Sunnybrook Chief of Emergency Services for North Toronto Ontario Health Team

Sept 27, 2019

To the North Toronto Ontario Health Team (OHT):

On behalf of the Department of Emergency Services at Sunnybrook Health Sciences Centre, I am writing this letter to demonstrate our support for the work of the North Toronto OHT partners to develop an integrated care delivery system and to create a new vision for health care which is centered around patients, families and caregivers.

The North Toronto OHT represents the full continuum of care, and brings a commitment to engage all relevant stakeholders, including patient representatives and primary care providers, to co-design an integrated system to serve individuals living in the community and seeking care in North Toronto. The partners of the North Toronto OHT have shown a strong sense of collaboration, working together to ensure connected care for patients that we serve. Through partnership projects in the past, the North Toronto OHT partners have demonstrated a track record of successful and innovative partnership initiatives focusing on the needs of patients, with a strong foundation to build upon for the transformation to come.

The Department of Emergency Services at Sunnybrook Health Sciences Centre fully supports the North Toronto Ontario Health Team, and is committed to working collaboratively with the OHT to support access to care and services. We look forward to being a part of a connected health care system, one that is easy and seamless for patients and families to navigate and transition through.

Sincerely,

Aikta Verma MD, MHSc, FRCPC
Chief, Department of Emergency Services, Sunnybrook Health Sciences Centre.
Assistant Professor, Division of Emergency Medicine, University of Toronto.

Sunnybrook
HEALTH SCIENCES CENTRE

Sunnybrook Health Sciences Centre
2075 Bayview Avenue,
Toronto, ON Canada M4N 3M5
t: 416.480.6100
www.sunnybrook.ca

September 30, 209

To the North Toronto OHT,

On behalf of the Division of Long Term Care at Sunnybrook Health Sciences Centre, I am writing this letter to express our support for the work of the North Toronto OHT partners to develop an integrated care delivery system and to create a new vision for health care centred around patients, families and caregivers.

The North Toronto OHT represents the full continuum of care, and brings a commitment to engage all relevant stakeholders, including patient representatives and primary care providers, to co-design an integrated system to serve individuals living in the community and seeking care in North Toronto. The partners of the North Toronto OHT have shown a strong sense of collaboration, working together to ensure connected care for patients that we serve. Through partnership projects in the past, the North Toronto OHT partners have demonstrated a track record of successful and innovative partnership initiatives focusing on the needs of patients, with a strong foundation to build upon for the transformation to come.

The Division of Long Term Care at Sunnybrook Health Sciences Centre fully supports the North Toronto Ontario Health Team, and is committed to working collaboratively with the OHT to support access to care and services. We look forward to being a part of a connected health care system, one that is easy and seamless for patients and families to navigate.

Sincerely,

Dr. Susan Deering

Division Lead, Long Term Care

Department of Family and Community Medicine

Sunnybrook Health Sciences Centre

Assistant Professor, University of Toronto

Sunnybrook
HEALTH SCIENCES CENTRE

Arthur P. Zaltz, BSc., MD, FRCSC, FACOG

Obstetrician & Gynecologist in Chief
Chief DAN Women & Babies Program
Associate Professor of Obstetrics and Gynecology
2075 Bayview Avenue,
Toronto, Ontario M4N 3M5
Tel: 416-480-4789, Fax: 416-480-4839
arthur.zaltz@sunnybrook.ca

September 26, 2019

To the North Toronto OHT,

On behalf of the Medical Advisory Committee (MAC) at Sunnybrook Health Sciences Centre, I am writing this letter to demonstrate our support for the work of the North Toronto OHT partners to develop an integrated care delivery system and to create a new vision for health care centred around patients, families and caregivers.

The North Toronto OHT represents the full continuum of care, and brings a commitment to engage all relevant stakeholders, including patient representatives and primary care providers, to co-design an integrated system to serve individuals living in the community and seeking care in North Toronto. The partners of the North Toronto OHT have shown a strong sense of collaboration, working together to ensure connected care for patients that we serve. Through partnership projects in the past, the North Toronto OHT partners have demonstrated a track record of successful and innovative partnership initiatives focusing on the needs of patients, with a strong foundation to build upon for the transformation to come.

The MAC at Sunnybrook Health Sciences Centre fully supports the North Toronto Ontario Health Team. This was achieved through a unanimous resolution at the September MAC meeting. We are committed to working collaboratively with the OHT to support access to care and services. We look forward to being a part of a connected health care system, one that is easy and seamless for patients and families to navigate and transition through.

Sincerely,

Arthur Zaltz, MD, BSc, FRCSC
Obstetrician and Gynecologist In-Chief
Chair, SHSC MAC

UNIVERSITY OF
TORONTO

Michelle Hladunewich MD, MSc, FRCPC
Professor of Medicine, University of Toronto
Physician-in-Chief, Department of Medicine, Sunnybrook Health Sciences Centre
2075 Bayview Avenue, Room D4-74, Toronto, Ontario, Canada M4N 3M5
Tel: 416-480-4592 Fax: 416-480-6191 e-mail: **michelle.hladunewich@sunnybrook.ca**

October 1, 2019

To the North Toronto OHT,

On behalf of the Department of Medicine at Sunnybrook Health Sciences Centre, I am writing this letter to convey our strong support for the work of the North Toronto OHT partners to develop an integrated care delivery system and to create a new vision for health care centered around patients, families and caregivers. This integration is critical not only to assist patients that have been hospitalized return to their community, but also to prevent illness and maintain a healthier community.

The North Toronto OHT represents the full continuum of care, and brings a commitment to engage all relevant stakeholders, including patient representatives and primary care providers, to co-design an integrated system to serve individuals living in the community and seeking care in North Toronto. The partners of the North Toronto OHT have shown a strong sense of collaboration, working together to ensure connected care for patients that we serve. Through partnership projects in the past, the North Toronto OHT partners have demonstrated a track record of successful and innovative partnership initiatives focusing on the needs of patients, with a strong foundation to build upon for the transformation to come. Further, there is a significant interest and desire to expand these collaborative partnerships to manage the numerous chronic medical conditions that cause morbidity and consume health care resources.

As such, the Department of Medicine at Sunnybrook Health Sciences Centre fully supports the North Toronto Ontario Health Team, and is committed to working collaboratively with the OHT to support access to care and services. We look forward to being a part of a connected health care system, one that is seamless for patients and families to navigate, and that supports care through its many transitions.

Sincerely,

M Hladunewich

Michelle Hladunewich MD, MSc, FRCPC
Professor of Medicine, University of Toronto
Divisions of Nephrology and Obstetrical Medicine
Physician-in-Chief, Department of Medicine, Sunnybrook Health Sciences Centre

Sunnybrook
HOLLAND MUSCULOSKELETAL PROGRAM

DIVISION OF ORTHOPAEDIC SURGERY

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f: 416.480.5886

Holland Centre Campus
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416.480.4941

C. GIMERA
ADMIN DIRECTOR
416.480.4884

October 1, 2019

North Toronto: Ontario Health Team

Valued Partners of the North Toronto OHT,

On behalf of the Holland Bone & Joint Program and Division of Orthopaedic Surgery at Sunnybrook Health Sciences Centre, I am writing this letter of support for the work of the North Toronto OHT partners to develop an integrated care delivery system and to create a new vision for health care centred around patients, families and caregivers. I commend your efforts developing, as an initial focus, preventative measures for our population of seniors.

The North Toronto OHT represents the full continuum of care, and brings a commitment to engage all relevant stakeholders, including patient representatives and primary care providers, to co-design an integrated system to serve individuals living in the community and seeking care in North Toronto. The partners of the North Toronto OHT have shown a strong sense of collaboration, working together to ensure connected care for patients that we serve. Through partnership projects in the past, the North Toronto OHT partners have demonstrated a track record of successful and innovative partnership initiatives focusing on the needs of patients, with a strong foundation to build upon for the transformation to come.

The Division of Orthopaedic Surgery and Holland Bone & Joint Program at Sunnybrook Health Sciences Centre fully supports the North Toronto Ontario Health Team, and is committed to working collaboratively with the OHT to support access to care and services. We look forward to being a part of a connected health care system, one that is easy and seamless for patients and families to navigate and transition through. As you are aware, our hospital program and orthopaedic group is a high volume patient care centre. We perform amongst the largest number of hip and knee total joint replacement surgeries for arthritis as well as surgery for traumatic musculoskeletal injury across the country on an annual basis. We have a strong clinical and academic mandate in our strategic plan for the continuum of arthritis care, with tremendous physical therapy, orthopaedic, and rheumatological expertise amongst our team members. We have over 22 practicing orthopaedic surgeons at the hospital encompassing the spectrum of sub-specialized care (spine, hip and knee, upper extremity, etc.). With our aging population, mobility issues and integrated care for frail seniors

DIVISION OF ORTHOPAEDIC SURGERY

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remain a very important issue for us. We support for the values and principles of OHTs, and we are keenly interested in working together with the North Toronto OHT to create a connected system. Please do not hesitate to contact me if I can be of ongoing assistance.

Sincerely,

Albert J.M. Yee, MD, MSc, FRCSC, FIOR
Professor of Surgery, Department of Surgery, Division of Orthopaedic Surgery
University of Toronto
Co-Director, U of T Department of Surgery Spine Program,
President (2019-21) Canadian Spine Society
Holland Bone and Joint Program Chief,
Marvin Tile Chair, Division Chief of Orthopaedic Surgery
Sunnybrook Health Sciences Centre.
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Sunnybrook
HEALTH SCIENCES CENTRE

Leading the way to improved quality of life

Palliative Care Consult Team

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Amy Nolen
Giovanna Sirianni
Sarah Torabi
Philippe Toupin
Rachel Wortzman
Lesia Wynnychuk
Irene Ying

Social Worker
Elaine Rapp

September 26, 2019

To the North Toronto OHT,

On behalf of the Division of Palliative Care at Sunnybrook Health Sciences Centre, I am writing this letter to demonstrate our support for the work of the North Toronto OHT partners to develop an integrated care delivery system and to create a new vision for health care centred around patients, families and caregivers.

As palliative care physicians, we understand the critical need for good communication across the spectrum of care to ensure that patients receive the right care, in the right place, at the right time. This need has become ever more urgent as our population ages and as good end-of-life care is becoming increasingly recognized as an important health care initiative to improve quality of life and ensure appropriate use of resources at end-of-life. We are happy to see that the North Toronto OHT partners represent the full continuum of care, and have shown a commitment to engage all relevant stakeholders, including patient representatives and primary care providers, to co-design an integrated system to serve individuals living in the community and seeking care in North Toronto.

The Division of Palliative Care at Sunnybrook Health Sciences Centre fully supports the North Toronto Ontario Health Team. We are committed to working collaboratively with the OHT to support access to care and services. We look forward to being a part of a connected health care system, one that is easy and seamless for patients and families to navigate and transition through.

Sincerely,

Dr. Irene Ying MD CCFP(PC) MHSc
Interim Medical Director and Division Head, Division of Palliative Care
Department of Family and Community Medicine, Sunnybrook HSC
Assistant Professor, University of Toronto

Sunnybrook
HEALTH SCIENCES CENTRE

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October 1, 2019

The North Toronto Ontario Health Team
http://northtorontooht.ca

TO WHOM IT MAY CONCERN:

On behalf of the Department of Psychiatry at Sunnybrook Health Sciences Centre, I am writing this letter to demonstrate our support for the work of the North Toronto OHT partners to develop an integrated care delivery system and to create a new vision for health care centred around patients, families and caregivers.

The North Toronto OHT represents the full continuum of care, and brings a commitment to engage all relevant stakeholders, including patient representatives and primary care providers, to co-design an integrated system to serve individuals living in the community and seeking care in North Toronto. The partners of the North Toronto OHT have shown a strong sense of collaboration, working together to ensure connected care for patients that we serve. Through partnership projects in the past, the North Toronto OHT partners have demonstrated a track record of successful and innovative partnership initiatives focusing on the needs of patients, with a strong foundation to build upon for the transformation to come.

The Department of Psychiatry at Sunnybrook Health Sciences Centre fully supports the North Toronto Ontario Health Team, and is committed to working collaboratively with the OHT to support access to care and services. We look forward to being a part of a connected health care system, one that is easy and seamless for patients and families to navigate and transition through.

Sincerely,

Ari Zaretsky

Ari Zaretsky, MD, FRCPC
Chief, Department of Psychiatry and
Vice President, Education
Sunnybrook Health Sciences Centre

Sunnybrook
SCHULICH HEART CENTRE

GIUSEPPE PAPIA, MD, MSc, FRCS(C)
ASSISTANT PROFESSOR, UNIVERSITY OF TORONTO
DIVISION OF VASCULAR SURGERY
DEPARTMENT OF CRITICAL CARE MEDICINE

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October 1, 2019

To the North Toronto OHT,

As a Vascular Surgeon and lead for the multidisciplinary Sunnybrook Limb Preservation Program and Project Saving Legs™ at Sunnybrook Health Sciences Centre, I am writing this letter to demonstrate our support for the work of the North Toronto OHT partners to develop an integrated care delivery system and to create a new vision for health care centred around patients, families and caregivers. In order to prevent major limb amputations in patients with diabetes and peripheral artery disease, these fragile patients require expedited multidisciplinary care both in and out of hospital. This integration of community based programs in primary care with expedited access to specialized care as needed is critical to saving patient's limbs from amputation, and to improving their quality of life. Integrating and supporting patients back into their community after specialized treatments ultimately maintains their dignity.

The North Toronto OHT represents the full continuum of care, and brings a commitment to engage all relevant stakeholders, including patient representatives and primary care providers, to co-design an integrated system to serve individuals living in the community and seeking care in North Toronto. The partners of the North Toronto OHT have shown a strong sense of collaboration, working together to ensure connected care for patients that we serve. Through partnership projects in the past, the North Toronto OHT partners have demonstrated a track record of successful and innovative partnership initiatives focusing on the needs of patients, with a strong foundation to build upon for the transformation to come.

The Sunnybrook Limb Preservation Program and Project Saving Legs™ at Sunnybrook Health Sciences Centre fully supports the North Toronto Ontario Health Team, and is committed to working collaboratively with the OHT to support access to care and services. We look forward to being a part of a connected health care system, one that is easy and seamless for patients and families to navigate and transition through.

Sincerely,

G. Papia, MD, MSc, FRCS(C)

J. Ross and Patricia Quigley Chair in Limb Preservation

Vascular & Endovascular Surgery, Critical Care Medicine

Schulich Heart Centre

Assistant Professor, U of T

Sunnybrook Health Sciences Centre

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Baycrest

27 Sept 2019

To the North Toronto OHT,

On behalf of the Department of Family and Community Medicine at Baycrest Health Sciences, I am writing this letter to demonstrate our support for the work of the North Toronto OHT partners to develop an integrated care delivery system and to create a new vision for health care centred around patients, families and caregivers.

From the discussions I have had with members of the Executive and Operations Committees of the North Toronto OHT, it represents the full continuum of care, and brings a commitment to engage all relevant stakeholders. I am most impressed by the active commitment to engage primary care practitioners in active co-design with the goal of an integrated system to serve individuals living in the community and seeking care in North Toronto. The partners of the North Toronto OHT have shown a strong sense of collaboration, working together to ensure connected care for patients that we serve. Through partnership projects in the past, the North Toronto OHT partners have demonstrated a track record of successful and innovative partnership initiatives focusing on the needs of patients, with a strong foundation to build upon for the transformation to come.

I am particularly excited by the North Toronto OHT partners' year 1 focus on seniors. Older adults with complex needs can be best served through integrated collaborative care networks, exactly as envisioned by the NT OHT partners. The focus on primary care of older adults with complex needs through enhanced primary interprofessional care, enabled through technology, is the best way to improve quality of life, quality of care and reduced hospitalizations in this population. The OHT has engaged leaders who have the specific knowledge and experience to help the OHT succeed in achieving its key performance indicators.

The Department of Family and Community Medicine at Baycrest Health Sciences fully supports the North Toronto Ontario Health Team, and is committed to working collaboratively with the OHT to support access to care and services. We look forward to being a part of a connected health care system, one that is easy and seamless for patients and families to navigate and transition through.

Finally, in my role as Chair of the Health Care of the Elderly Program Committee for the College of Family Physicians of Canada, I can say that there is national interest in the results of this bold and innovative approach to population-based care. I look forward to future participation as the North Toronto OHT moves from development into action to support our large population of frail and complex older adults.

Sincerely,

Sid Feldman MD CCFP (COE) FCFP CMD
Chief, Department of Family and Community Medicine, Baycrest Health Sciences
Associate Professor, Department of Family and Community Medicine, University of Toronto
Chair, Health Care of the Elderly Committee, College of Family Physicians of Canada
T. 416 785 2500 ext. 2118
E. sfeldman@baycrest.org

Table 2.1.1

NAME OF GROUP/FHT *From dropdown list, select the name of the participating group or FHT, as registered with the Ministry or select 'solo fee-for-service' if not part of a group practice. If a group is not found in this list, add it to Other (column H).*	**PHYSICIAN NAME** *(Last name, First name) If all physicians in group (column A) are included in the application, note as N/A*	**PRACTICE MODEL** *Select model type from dropdown list . If 'other' is selected, please specify model type in Other (column H).*
PEM - SUNNYBROOK FHO	N/A	FHT - Family Health Team
FHT - DON MILLS FHT	N/A	FHT - Family Health Team
PEM - NORTH WEST TORONTO FHG	Abells, Yoel	FHG - Family health group
PEM - NORTH WEST TORONTO FHG	Abells, Dara	FHG - Family health group
PEM - NORTH WEST TORONTO FHG	Altman, David	FHG - Family health group
PEM - NORTH WEST TORONTO FHG	Cord, Stephen	FHG - Family health group
PEM - NORTH WEST TORONTO FHG	Fisher, Christina	FHG - Family health group
PEM - NORTH WEST TORONTO FHG	Goldberg, Orli	FHG - Family health group
PEM - NORTH WEST TORONTO FHG	Shievitz, Nicole	FHG - Family health group
PEM - OTTER CREEK FHO	Beyers, Leslie	FHO - Family health organization
PEM - OTTER CREEK FHO	Fleming, Karen	FHO - Family health organization
PEM - OTTER CREEK FHO	Murphy, Claire	FHO - Family health organization
PEM - OTTER CREEK FHO	Wyman, Jennifer	FHO - Family health organization
PEM - OTTER CREEK FHO	Joyce, Susan	FHO - Family health organization
PEM - OTTER CREEK FHO	Newman, Barbara	FHO - Family health organization
PEM - OTTER CREEK FHO	Lalani, Fereshte	FHO - Family health organization
PEM - OTTER CREEK FHO	Rosen, Gili	FHO - Family health organization
PEM - OTTER CREEK FHO	Salz, Liad	FHO - Family health organization
PEM - LAWRENCE PARK FHO	Zoudis, Adamantios	FHO - Family health organization
PEM - LAWRENCE PARK FHO	Somerville, Susan	FHO - Family health organization
PEM - LAWRENCE PARK FHO	Young, Gregory	FHO - Family health organization
PEM - LAWRENCE PARK FHO	Chen, Jeyla	FHO - Family health organization
PEM - LAWRENCE PARK FHO	Bennett, Margaret	FHO - Family health organization
PEM - LAWRENCE PARK FHO	Kavanagh, Doug	FHO - Family health organization
PEM - CENTRAL TORONTO FHO	Legault, Pierre-Marc	FHO - Family health organization
PEM - CENTRAL TORONTO FHO	Gorfinkel, Iris	FHO - Family health organization
PEM - CENTRAL TORONTO FHO	Santo, William	FHO - Family health organization
PEM - CENTRAL TORONTO FHO	Stulberg, Jennifer	FHO - Family health organization
PEM - MAGENTA HEALTH FHG	Sherwin, Heather	FHG - Family health group
PEM - MAGENTA HEALTH FHG	Gans, Nathalie	FHG - Family health group
PEM - FUTURITY MEDICAL FHG	Waks, Joshua	FHG - Family health group
PEM - YONGELINE FHO	Segal, Orit	FHO - Family health organization
PEM - COMPLETE CARE FHO	Fulton, Jessica	FHO - Family health organization
PEM - EAST GTA SIXTH FHO	Singh, Birinder	FHO - Family health organization
FFS - SOLO FEE-FOR-SERVICE	Crampton, Noah	FFS - Solo fee-for-service
OTHER, PLEASE SPECIFY	Hakoun, Jack	CCM - Comprehensive care model
OTHER, PLEASE SPECIFY	Dilli, Erol	Other
OTHER, PLEASE SPECIFY	Hsueh, Jenny	Other
OTHER, PLEASE SPECIFY	Deering, Susan	Other
OTHER, PLEASE SPECIFY	Ying, Irene	Other
OTHER, PLEASE SPECIFY	Cohen, Carole	Other
FFS - SOLO FEE-FOR-SERVICE	de Mello Brandao, Jose Ricardo	FFS - Solo fee-for-service

Table 2.1.2

NAME OF ORGANIZATION *Provide the legal name of the member organization*	**TYPE OF ORGANIZATION** *Select type from dropdown list, if 'other' please specify type in column C*	**OTHER ORGANIZATION TYPE**	**PRIMARY CONTACT** *NAME (Last name, First name)*	**PRIMARY CONTACT** *TITLE (e.g., Director)*	**PRIMARY CONTACT** *Business / Practice Address*	**PRIMARY CONTACT** *City / Community (e.g., Toronto)*	**PRIMARY CONTACT** *Postal Code*
Baycrest Hospital	HOSPITALS		Scott Ovenden	Vice-President, Clinical Programs & Corporate Performance	3560 Bathurst St	North York	M6A 2E1
LOFT Community Services	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		Heather McDonald	Chief Executive Officer	15 Toronto St	Toronto	M5C 2E3
TCLHIN Home & Community Care	OTHER, PLEASE SPECIFY		Tess Romain	Chief Executive Officer	425 Bloor St E	Toronto	M4X 1L7
SE Health (member of the SE family of companies)	HOME CARE SERVICE PROVIDER ORGANIZATION		Shirlee Sharkey	Director	90 Allstate Pkwy #300	Markham	L3R 6H3
SPRINT Senior Care	COMMUNITY SUPPORT SERVICES		Stacy Landau	Chief Executive Officer	140 Merton St	Toronto	M4S 1A1
Sunnybrook Health Sciences Centre	HOSPITALS		Andy Smith	President and Chief Executive Officer	2075 Bayview Ave	Toronto	M4N 3M5
Unison Health and Community Services	COMMUNITY HEALTH CENTRES		Michelle Joseph	Chief Executive Officer	12 Flemington Rd	Toronto	M6A 2N4
VHA Home HealthCare	HOME CARE SERVICE PROVIDER ORGANIZATION		Carol Annett	Chief Executive Officer	30 Soudan Ave. Suite 600	Toronto	M6A 3B4
Vibrant Healthcare Alliance	OTHER, PLEASE SPECIFY	Community Health Centre; Community Social Services; and Multi-	Simone Atungo	Chief Executive Officer	2398 Yonge Street	Toronto	M4P 2H4

Table 2.3

TEAM MEMBER *(Last name, First name)*	**OTHER AFFILIATED TEAM(S)** *List the other teams that the member has signed on to or agreed to work with.*	**FORM OF AFFILIATION** *Select from dropdown list to indicate whether the member is a signatory member of the other team(s).*	**REASON FOR AFFILIATION** *Provide a rationale for why the member chose to affiliate themself with multiple teams (e.g., member provides services in multiple regions).*
LOMAS, WILL / CAWLEY, BARBARA (VHA)	Western Ontario Health Team	SIGNATORY	VHA provides services in multiple regions
McALLUM, VICTORIA / BEAN, COURTNEY (VHA)	Mississauga Ontario Health Team	OTHER	VHA provides services in multiple regions
BLUM, JENNIFER / ANNETT, CAROL (VHA)	North York Central Health System	SIGNATORY	VHA provides services in multiple regions
ANNETT, CAROL / CAWLEY, BARBARA (VHA)	East Toronto Health Partnership	SIGNATORY	VHA provides services in multiple regions
McALLUM, VICTORIA / BEAN, COURTNEY (VHA)	Central West - Hills of Headwater - Dufferin-Caledon	OTHER	VHA provides services in multiple regions
McALLUM, VICTORIA / BEAN, COURTNEY (VHA)	Central West - Brampton North Etobicoke	OTHER	VHA provides services in multiple regions
PROULX, CHRISTINE / BEAN, COURTNEY (VHA)	Ottawa East Health Team	OTHER	VHA provides services in multiple regions
PROULX, CHRISTINE / BEAN, COURTNEY (VHA)	Ottawa Health Team	OTHER	VHA provides services in multiple regions
KLOPP, JOY / CAWLEY, BARBARA (VHA)	Scarborough Ontario Health Team*	SIGNATORY	VHA provides services in multiple regions
TEDESCO, SANDRA / NICHOL, KATHRYN (VHA)	Connected Kids (Children with Medical Complexity in the GTA)**	SIGNATORY	VHA provides services in multiple regions
Ovenden, Scott (Baycrest)	North York Central Ontario Health Team	SIGNATORY	Baycrest is a regional provider supporting several large acute care hospitals. Additionally, ambulatory and outreach services cross several traditional catchment areas.
Toronto Central LHIN	East Toronto Health Partners	SIGNATORY	For Toronto Central LHIN: We are participating in multiple OHTs due to the staff and experience we have to support care coordination. In the future, care coordination staff may be part of an OHT team to facilitate the 24/7 coordination of care required under the OHT guidelines. The LHIN currently provides care coordination / case management across the LHIN boundaries, which overlap with at least two aspiring OHT catchment areas.
Toronto Central LHIN	Downtown East Ontario Health Team	SIGNATORY	For Toronto Central LHIN: We are participating in multiple OHTs due to the staff and experience we have to support care coordination. In the future, care coordination staff may be part of an OHT team to facilitate the 24/7 coordination of care required under the OHT guidelines. The LHIN currently provides care coordination / case management across the LHIN boundaries, which overlap with at least two aspiring OHT catchment areas.
Toronto Central LHIN	Mid-West Toronto Ontario Health Team	SIGNATORY	For Toronto Central LHIN: We are participating in multiple OHTs due to the staff and experience we have to support care coordination. In the future, care coordination staff may be part of an OHT team to facilitate the 24/7 coordination of care required under the OHT guidelines. The LHIN currently provides care coordination / case management across the LHIN boundaries, which overlap with at least two aspiring OHT catchment areas.
Toronto Central LHIN	West Toronto Ontario Health Team	SIGNATORY	For Toronto Central LHIN: We are participating in multiple OHTs due to the staff and experience we have to support care coordination. In the future, care coordination staff may be part of an OHT team to facilitate the 24/7 coordination of care required under the OHT guidelines. The LHIN currently provides care coordination / case management across the LHIN boundaries, which overlap with at least two aspiring OHT catchment areas.
McDonald, Heather (LOFT)	Southlake Community OHT	SIGNATORY	LOFT provides a specific and unique suite of services across a broad geography that are each designed to support local needs. It is important to LOFT to participate in the design and evolution of care for all regions where we consider ourselves part of the community and have a vested interest in the success of this process.
McDonald, Heather (LOFT)	North York Central OHT	SIGNATORY	LOFT provides a specific and unique suite of services across a broad geography that are each designed to support local needs. It is important to LOFT to participate in the design and evolution of care for all regions where we consider ourselves part of the community and have a vested interest in the success of this process.

McDonald, Heather (LOFT)	Eastern York North Durham	SIGNATORY	LOFT provides a specific and unique suite of services across a broad geography that are each designed to support local needs. It is important to LOFT to participate in the design and evolution of care for all regions where we consider ourselves part of the community and have a vested interest in the success of this process.
McDonald, Heather (LOFT)	North West Toronto OHT	SIGNATORY	LOFT provides a specific and unique suite of services across a broad geography that are each designed to support local needs. It is important to LOFT to participate in the design and evolution of care for all regions where we consider ourselves part of the community and have a vested interest in the success of this process.
McDonald, Heather (LOFT)	Mid East Toronto OHT *	SIGNATORY	LOFT provides a specific and unique suite of services across a broad geography that are each designed to support local needs. It is important to LOFT to participate in the design and evolution of care for all regions where we consider ourselves part of the community and have a vested interest in the success of this process.
SHARKEY, SHIRLEE (SE Health)	Great Barrie Area OHT	Signatory	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Brampton, Bramalea, North Etobicoke, Malton, West Woodbridge OHT	Community Partner	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Durham OHT	Signatory	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	East York OHT	Signatory	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Guelph and Area OHT	Community Partner	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Hamilton OHT	Signatory	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Hills of Headwaters	Community partner	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	London Middlesex OHT	Community Partner	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	North Western Toronto OHT	Signatory	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	North York Central Health System OHT	Signatory	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Northumberland OHT	Affiliated Organization	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Ottawa Health Team/Equipe Santa Ottawa OHT	Affiliated Organization	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Peterborough OHT	Signatory	SE Health is presently a provider of home and community care to this OHT – specifically integrated palliative care services
SHARKEY, SHIRLEE (SE Health)	Southlake OHT	Signatory	SE Health is presently a provider of home and community care to this OHT, including partner on the Southlake@ Home initiative
SHARKEY, SHIRLEE (SE Health)	To Be Named by the Kids OHT	Signatory	SE Health is presently a provider of home and community care to this OHT, including significant volumes providing care to children with complex medical conditions
SHARKEY, SHIRLEE (SE Health)	West York Region OHT	Signatory	SE Health is presently a provider of home and community care to this OHT, including a strong collaborative relationship established with Mackenzie Health within their rehabilitation care program
SHARKEY, SHIRLEE (SE Health)	Three Rivers	Signatory	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Cornwall and Area OHT	Signatory	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Scarborough (Scarborough Health Network) OHT	Signatory	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Windsor Essex OHT	Signatory	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	North Rideau Health Alliance	Signatory	SE Health is presently a provider of home and community care to this OHT

SHARKEY, SHIRLEE (SE Health)	South East Ontario Health Team	Affiliated Organization	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Upper Canada Health Link OHT	Signatory	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Connected Kids	Signatory	SE Health is presently a provider of home and community care to this OHT, including a primary provider of child and family care within the TC LHIN for children with both acute and chronic conditions
SHARKEY, SHIRLEE (SE Health)	Brantford Brant OHT	Community Partner	SE Health is presently a provider of home and community care to this OHT
SHARKEY, SHIRLEE (SE Health)	Oakville-Milton OHT	Signatory	SE Health is presently a provider of home and community care to this OHT
Joseph,Michelle (Unison)	North West OHT	SIGNATORY	Unison has service sites in different OHT areas
Joseph,Michelle (Unison)	Mid West OHT	SIGNATORY	Unison has service sites in different OHT areas
Joseph,Michelle (Unison)	North York OHT	SIGNATORY	Unison has service sites in different OHT areas

* In development
** Innovative

Table 2.6.1

NAME OF GROUP *From the dropdown list, select the name of the participating physician group, as registered with the Ministry or select 'solo fee-for-service' if not part of a group practice. If a group is not found in this list, add it to Other (column F).*	**PHYSICIAN NAME** *(Last name, First name) If all physicians in group (column A) are included in the application, leave this column blank.*	**PRACTICE MODEL** *Select model type from dropdown list. If 'other' is selected, please specify model type in Other (column F).*	**NUMBER OF PHYSICIANS** *For participating physician groups, please indicate the number of physicians who are part of the group. (e.g., 850)*	**COLLABORATION OBJECTIVES (E.G., EVENTUAL PARTNERSHIP AS PART OF TEAM) AND STATUS OF COLLABORATION (E.G., IN DISCUSSION)**	**OTHER** *If the physician group is not listed or works in a practice model that is not listed, please indicate here.*
OTHER, PLEASE SPECIFY	Ying, Irene	Other		Endorsement	Sunnybrook Health Sciences Centre, Division Lead of Palliative Care
OTHER, PLEASE SPECIFY	Deering, Susan	Other		Endorsement	Sunnybrook Health Sciences Centre, Division Lead of Long-Term Care
OTHER, PLEASE SPECIFY	Fleming, Karen	Other		Endorsement	Sunnybrook Health Sciences Centre, Chief of Department of Family and Community Medicine
OTHER, PLEASE SPECIFY	Papia, Giuseppe	Other		Endorsement	Sunnybrook Health Sciences Centre, Vascular and Endovascular Surgeon and Critical Care Medicine Specialist
OTHER, PLEASE SPECIFY	Zaltz, Arthur	Other		Endorsement	Sunnybrook Health Sciences Centre, Chair of Medical Advisory Committee
OTHER, PLEASE SPECIFY	Yee, Albert	Other		Endorsement	Sunnybrook Health Sciences Centre, Chief of the Holland Musculoskeletal (MSK) Program
PEM - HOUSE CALLS GROUP COE		Other	7	In discussion to be physician members of OHT	GP COE
OTHER, PLEASE SPECIFY	Feldman, Sid	Other		Endorsement	Chief, Department of Family and Community Medicine, Baycrest Health Sciences Chair, Health Care of the Elderly Committee, College of Family Physicians of Canada
OTHER, PLEASE SPECIFY		Other	10	In discussion to be physician members of OHT	Lawrence Park Cardiology

Table 2.6.2

NAME OF NON-MEMBER ORGANIZATION *Provide the legal name of the collaborating organization.*	TYPE OF ORGANIZATION *Select type from dropdown list, if 'other' please specify type in column C*	OTHER ORGANIZATION TYPE	COLLABORATION OBJECTIVES (E.G., EVENTUAL PARTNERSHIP AS PART OF TEAM) AND STATUS OF COLLABORATION (E.G., IN DISCUSSION)
Alzheimer's Society – Toronto	COMMUNITY SUPPORT SERVICES		Collaborator / In discussion
Bellwoods Centres for Community Living Inc.	COMMUNITY SUPPORT SERVICES		Collaborator / In discussion
Centres d'Accueil Héritage	COMMUNITY SUPPORT SERVICES		Collaborator / In discussion
PACE	COMMUNITY SUPPORT SERVICES		Collaborator / In discussion
Ontario Telemedicine Network	OTHER, PLEASE SPECIFY	Telemedicine	Collaborator / In Discussion OTN virtual care supports and standards to support the implementation of a single virtual care platform for patients and providers in the NT OHT
OntarioMD	OTHER, PLEASE SPECIFY	OMA	Collaborator / In Discussion Engage with OntarioMD to support enabling of information to be shared with other OHT partners and patients through MyChart
Toronto Paramedic Service	OTHER, PLEASE SPECIFY	Emergency Health Services	Collaborator / In discussion
1to1 Rehab	HOME CARE SERVICE PROVIDER ORGANIZATION		Collaborator / In Discussion
CarePartners	HOME CARE SERVICE PROVIDER ORGANIZATION		Collaborator / In discussion
CBI Home Health	HOME CARE SERVICE PROVIDER ORGANIZATION		Collaborator / In discussion
Circle of Care Home Care Services	HOME CARE SERVICE PROVIDER ORGANIZATION		Collaborator / In discussion
Paramed Home Health Care	HOME CARE SERVICE PROVIDER ORGANIZATION		Collaborator / In discussion
S.R.T. MedStaff	HOME CARE SERVICE PROVIDER ORGANIZATION		Collaborator / In discussion
Spectrum Health Care	HOME CARE SERVICE PROVIDER ORGANIZATION		Collaborator / In discussion
Closing the Gap Health Care	HOME CARE SERVICE PROVIDER ORGANIZATION		Collaborator / In discussion

Bellwood Health Services	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		Collaborator / In discussion
Sunnybrook Research Institute; Family Navigation Project	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		Collaborator / In discussion
Hope + Me – Mood Disorders Association of Ontario	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		Collaborator / In discussion
Skylark	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		Collaborator / In discussion
Toronto North Support Services	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		Collaborator / In discussion
Plexxus	OTHER, PLEASE SPECIFY	Supply Chain	Collaborator / In discussion
Regional Geriatric Program	OTHER, PLEASE SPECIFY		Collaborator / In discussion
Suomi Koti	LONG-TERM CARE HOMES		Collaborator / In discussion
eHealth Ontario	OTHER, PLEASE SPECIFY	Ontario Health	Collaborator / In Discussion The aim of the NT OHT is to utilize ConnectingOntario to support identification/tracking and information sharing in the future. This will require eHealth Ontario support.
Health Shared Services Ontario	OTHER, PLEASE SPECIFY	Ontario Health	Collaborator / In Discussion Integration to share CHRIS data into MyChart to support information sharing with patients and partners.
Hospice Toronto	OTHER, PLEASE SPECIFY	Palliative Care	Collaborator / In discussion
Nurse Next Door	HOME CARE SERVICE PROVIDER ORGANIZATION		Collaborator / In discussion

Table 2.8

SERVICE	PROPOSED FOR YEAR 1 *Select Yes/No from dropdown list*	CAPACITY IN YEAR 1 *How many patients can your team currently serve?*	PREDICTED DEMAND IN YEAR 1 *Of year 1 population, how many patients are predicted to need this service?*	DESCRIPTION *Indicate which team member(s) will provide the service. If a proposed service differs from your existing scope, explain how you will resource the new service. If there is a gap between capacity and demand, identify plans for closing the gap.*
Interprofessional team-based primary care	Yes	5,786	4,408	Baycrest, Vibrant, Unison, Primary Care, Sunnybrook, SPRINT (House Calls)
Physician primary care	Yes	37,307	8,060	FHO, FHGs and FFS physicians, Vibrant, Unison
Acute care – inpatient	Yes	35,000	1,655	Sunnybrook
Acute care – ambulatory	Yes	3,319	3,319	Sunnybrook
Home care	Yes	8,120	3,855	TC LHIN Home and Community, SE Health, VHA
Community support services	Yes	4,440	4,440	SPRINT
Mental health and addictions	Yes	51	3,170	LOFT - We plan to reach out to other collaborator organizations to address this gap in service. Mental health and addictions needs will also be addressed through other services (e.g. Primary Care)
Long-term care homes	Yes		881	We are working with several long-term care partners to address this.
Other residential care	Yes	265	265	LOFT, SPRINT
Hospital-based rehabilitation and complex care	Yes	312	312	Sunnybrook, Baycrest
Community-based rehabilitation	Yes		1,265	While one of our team member organization (VHA) does offer community-based rehab services, we will work with other collaborator organizations to address this gap in service.
Short-term transitional care	Yes	159	159	Sunnybrook, LOFT, SPRINT, VHA, TC LHIN Home and Community
Palliative care (including hospice)	Yes	2,584	2,584	Sunnybrook, Baycrest, TC LHIN Home and Community.
Emergency health services (including paramedic)	Yes	65,000	2,856	Sunnybrook
Laboratory and diagnostic services	Yes	7,503	7,503	Sunnybrook
Midwifery services	No			
Health promotion and disease prevention	Yes	6,440	6,440	All
Other social and community services (including municipal services)	Yes	3,876	3,876	All
Other health services (please specify)	No			

APPROXIMATE SIZE OF YEAR 1 POPULATION (FROM QUESTION 1.2):	10,000

Table 6.6

RISK CATEGORY *Select risk category from dropdown list*	RISK SUB-CATEGORY *Select risk sub-category from dropdown list*	DESCRIPTION OF RISK	RISK MITIGATION
RESOURCES RISKS	INFORMATION TECHNOLOGY	Technology is central to the success of an Ontario Health Team to streamline care and measure quality and performance. Currently, not all partners, including primary care physicians, use a common IT platform(s) and/or system(s). This limits an OHT's ability to share, access, provide input to an EMR, and share data. Additionally, any new IT infrastructure would require financial investment. OHTs cannot operate in silos in building digital platforms; we require at minimum a degree of interoperability	Leverage existing provincial IT assets and infrastructure where possible, and work collaboratively with partners and the Ministry to address IT infrastructure challenges, and implement best practices. Require a common platform for all OHTs to access (particularly imp. for urban OHTs)
RESOURCES RISKS	HUMAN RESOURCES	Health human resource challenges (e.g. access to PSWs and other allied health professionals) to provide preventative care and support to clients, patients and caregivers to avoid acute care utilization/admission when and where possible.	The North Toronto OHT will work collaboratively among partners, the TC LHIN and the Ministry to identify and mitigate potential gaps where possible.
RESOURCES RISKS	HUMAN RESOURCES	Wage/compensation compression when integrating sectors with significantly different compensation packages (salaries and benefits - e.g. HOOPP); despite potentially similar skills sets/education	Further assessment is required at this time.
RESOURCES RISKS	FINANCIAL	The redesign of care for our Year 1 target population may require providing care above the currently outlined service maximums. This may require additional resources/funding above and beyond the current funded allocation (e.g. increase home and community care supports).	Further assessment is required at this time. The North Toronto OHT will work collaboratively among partners including the TC LHIN and the Ministry.
RESOURCES RISKS	FINANCIAL	Single Funding envelope; equitable access to resources (e.g. there is currently no dedicated CM&A provider - resource allocations will need to occur to rectify this)	Reviewing funding formulas when they become available and working collaboratively with the MoH so that each OHT member is comfortable with risks and rewards.
RESOURCES RISKS	FINANCIAL	Financial resources are required to enable digital information sharing amongst OHT partners. Additionally, financial resources will be required to ensure digital assets meet the requirements of digital health information exchange policies.	Work collaboratively with provincial and regional partners to enhance what has already been developed and implemented to better support digital information sharing.
RESOURCES RISKS	FINANCIAL	Lack of actuarial skill within both the funder and providers to accurately assess risk and determine appropriate transfer of financial risk.	Incremental progress in funding reform toward value based structures. Will need to develop skills in risk coding in care delivery which will also require I.T. infrastructure investment.
COMPLIANCE RISKS	LEGISLATIVE (INCL. PRIVACY)	PHIPA (including but not limited to collection of, access to, and disclosure of personal health information, and security requirements)	Policies and procedures will be developed to ensure both individual (partner) and collective compliance. Steps will be taken to ensure that PHI will only be disclosed to members involved in the patient's 'circle of care'. The North Toronto OHT will review options and will work with the Ministry to ensure appropriate next steps.
COMPLIANCE RISKS	LEGISLATIVE (INCL. PRIVACY)	PSLRTA and Labour Relations Act (including but not limited to: labour relation rules, broader impacts to health system integrations/mergers of unionized and non-union entities, etc.)	Work collaboratively with the Ministry to assess and determine applicability of legislation and associated requirements, risks and impacts.
COMPLIANCE RISKS	LEGISLATIVE (INCL. PRIVACY)	Not all OHT partners are permitted to access provincial assets like ConnectingOntario that facilitate information sharing as they are not in the approved HIC list that is allowed access.	Work collaboratively with Ministry to enable access and contribution of data to ConnectingOntario from non-approved HIC types that are part of the OHT.
COMPLIANCE RISKS	LEGISLATIVE (INCL. PRIVACY)	HCCSA (including but not limited to agency status, funding and performance agreements, service maximums, etc.)	Work collaboratively with the Ministry and Ontario Health to determine requirements.
COMPLIANCE RISKS	LEGISLATIVE (INCL. PRIVACY)	Connecting Care Act (Integrated Care Delivery Systems designation, and integrations/amalgamations)	Work with the Ministry and Ontario Health to ensure that the North Toronto OHT will satisfy the requirements for Integrated Care Delivery Systems (ICDS) designation, and work to develop the specific accountability agreements required to facilitate the delivery of services from multiple sectors within an integrated care model.
PARTNERSHIP RISKS	OTHER	Change management	An effective change management strategy will be developed to support all partners within the North Toronto OHT. The quadruple aim will be embedded throughout, along with the principles of rapid-learning and improvement to harness assets available locally and provincially, and to address gaps in timely and responsive ways.
PARTNERSHIP RISKS	GOVERNANCE	Formalizing a single accountability framework across all Boards and still ensuring independence.	Leveraging existing resources from the MoH on collaborative governance and working through a principle based approach and a common vision to drive decision making.
PARTNERSHIP RISKS	GOVERNANCE	Lack of policy and/or payment models in place to incent physicians to be jointly accountable and aligned to OHT goals.	Grow network of primary care over longer period of time; seek to support the development of a governance framework for Primary Care providers who are attributed to the North Toronto OHT such that greater alignment and shared accountability may be achieved.
PARTNERSHIP RISKS	OTHER	Urban centres will need to partner with Neighbouring OHTs to care for their patients to ensure there is continuity of care	Use Community of Practice forums and existing OHTs in Full Application to advance discussions and early thinking
PARTNERSHIP RISKS	OTHER	Home Care contracts and system re-design	Need to work collaboratively with Home Care sector, LHINs and the MoH to advance discussions

Table A2

ROLE/FUNCTION	**ORGANIZATIONS** *Which organizations/members of the team will carry out the proposed role/function*	**Delivery Model** *What type of provider (dedicated home care coordinator, FHT allied health professional, contracted service provider nurse, etc.) would be providing the service and how (in-person in a hospital, virtually, in the home, etc.*

Please Refer to written answer for Appendix A2

Table B1

MEMBER	HOSPITAL INFORMATION SYSTEM INSTANCES *Identify vendor, version, and presence of clustering*	ELECTRONIC MEDICAL RECORD *Identify vendor and version*	ACCESS TO OTHER CLINICAL INFORMATION SYSTEMS *E.g., Other provincial systems such as CHRIS, or other systems to digitally store patient information*	ACCESS TO PROVINCIAL CLINICAL VIEWERS *ClinicalConnect or ConnectingOntario*	DO YOU PROVIDE ONLINE APPOINTMENT BOOKING? *Yes/No*	USE OF VIRTUAL CARE *Indicate type of virtual care and rate of use by patients where known*	PATIENT ACCESS CHANNELS *Indicate whether you have a patience access channel and if it is accessible by your proposed Year 1 target population*
Baycrest Hospital	Meditech MAGIC 5.6.6 Vendor: Meditech Not Clustered	PointClickCare	HDIRS	ConnectingOntario	No	Virtual Visits (OTN eVisits pilot), OTN eConsult, OTN Telemedicine, Telepsychiatry, and telephone visits with IPCT and ICCT teams. FY18/19- 1,664 virtual care encounters through OTN (for patients within North Toronto)	MyChart (expansion pending) Accessible by Year 1
LOFT Community Services	N/A	VitalHub Piroette v5 Catalyst v1.1 Acutenet v9.1.2.(upgrading to v9.1.4 soon)	No	ConnectingOntario	No	OTN Telemedicine, OTN eConsult FY18/19- 34 virtual care encounters through OTN	No
SE Health (member of the SE family of companies)	N/A	Procura v9	CHRIS/HPG	No	Yes	Virtual Visits, Telephone, and Secure Messaging FY18/19- 5,000 encounters (for patients in Toronto region)	Yes- Elizz Accessible by Year 1
SPRINT Senior Care	N/A	Juno OSCAR (Pine Villa) TELUS MedAccess (HouseCalls) Client Information Management System (CIMS) Build 912	IAR	ConnectingOntario	No	OTN Telemedicine Went live in FY19/20	MyChart- (in-progress)
Sunnybrook Health Sciences Centre	SunnyCare Vendor: Sunnybrook Health Sciences Centre Not Clustered	QHR: Accuro EMR (various clinics) TELUS: Practice Solutions (Family Practice) OSCAR (various clinics) PointClickCare (Long-Term-Care) IMD Soft MetaVision (ICU) Phillips OBTV (Women and Babies)	HDIRS, PRO, HPG/eCCP (in-progress)	ConnectingOntario	Yes	Asynchronous Secure Messaging (through MyChart), Virtual Visits (OTN eVisits), OTN eConsult, and OTN Telemedicine. FY18/19- 3,749 virtual care encounters through OTN (across Ontario)	MyChart Accessible by Year 1
Unison Health and Community Services	N/A	TELUS Nightingale on Demand v9.4.0.8 (Moving to TELUS Practice Solutions)	No	ConnectingOntario (in-progress)	No	No	No
VHA Home HealthCare	N/A	GoldCare Cloudcare v17 Pixalere v7.3	CHRIS/HPG	No	No	Telephone consults with patients Pixalere for provider consults FY18/19- 498 video visits for patients in North Toronto	MyChart (in-progress)
Vibrant Healthcare Alliance	N/A	TELUS Nightingale on Demand v9.4.0.8 (Moving to TELUS Practice Solutions)	No	ConnectingOntario	No	OTN eConsults, OTN Telemedicine, telephone consults FY18/19- 4,404 through OTN encounters and telephone encounters	No
TCLHIN Home and Community Care	N/A	CHRIS	No	ConnectingOntario	No	OTN telehomecare and telemedicine FY18/19- 9 through OTN encounters and 559 telehomecare patients	No
Dr. Yoel Abells	N/A	QHR Accuro EMR	No	ConnectingOntario	No	Telephone consults with patients OTN eConsult	No
Dr. Jocelyn Charles	N/A	TELUS: Practice Solutions	No	ConnectingOntario	No	Telephone consults with patients OTN eConsult	MyChart
Dr. Karen Fleming	N/A	INdiviCare 4	No	ConnectingOntario	No	Telephone consults with patients OTN eConsult	MyChart