Readiness Self-Assessment for the West Toronto Ontario Health Team May 15th, 2019

This document is being submitted in response to the Ontario Ministry of Health and Long-Term Care's Open Call for Readiness Self-Assessments for proposed Ontario Health Teams.

Members of the proposed West Toronto Ontario Health Team have demonstrated a history of formally and informally working with one another to advance integrated care. Through this history, members have built trust and are willing to move forward in this next phase of integration. Further, the group is committed to expanding to include new members, to meet the care needs of West Toronto.

Ontario Health Team
Self-Assessment Form

Overview of the Process to Become an Ontario Health Team:

- The Self-Assessment is the first of a multi-stage Readiness Assessment process to become an Ontario Health Team Candidate.

    1. **Self-Assessment (open call):** Interested groups of providers and organizations are invited to submit a Self-Assessment. Submissions will be evaluated to determine the likelihood that groups would be able to submit a comprehensive Full Application and adhere to the readiness criteria for Ontario Health Team Candidates set out in the *Ontario Health Teams: Guidance Document for Health Care Providers and Organizations.*

    2. **Full Application (invitational):** Based on Self-Assessment evaluations, selected groups will be invited to complete a Full Application.

    3. **In-Person Visits (invitational):** Based on Full Application scoring, a short list of groups will be selected for in-person visits in order to identify those most ready to begin implementation of the Ontario Health Team model.

- This process will be run on a regular basis, with further application dates to be communicated at a later date. All groups of providers and organizations who participate in the assessment process will receive access to supports that will help improve readiness for eventual implementation of the Ontario Health Team model.

Guidance for Completing the Self-Assessment:

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

Ontario Health Team
Self-Assessment Form

Please note:

- The costs of preparing and submitting a Self-Assessment and a Full Application or otherwise participating in this Ontario Health Team Readiness Assessment process (the "Application Process") are solely the responsibility of the applicant(s). The Ministry will not be responsible for any expenses or liabilities related to the Application Process.

- This Application Process is not intended to create any contractual or other legally enforceable obligation on the Ministry (including the Minister and any other officer, employee or agency of the Government of Ontario), the applicant or anyone else.

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

- Applications are accepted by the Ministry only on condition that an applicant submitting an application thereby agrees to all of the above conditions and agrees that any information submitted may be shared with any agency of Ontario.

- In addition, the Ministry may disclose the names of the successful applicants and any other material that is subject to the public access provisions of FIPPA.

Ontario Health Team
Self-Assessment Form

Part I: General Information and Commitments

Who are the members of your team?

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

The West Toronto OHT consists of dedicated providers from across the care continuum that are committed to the vision for OHT in service to our community of Toronto West. The anchor members of the team are as follows (and please refer to Appendix 1 for additional details):

Acute Care: Unity Health - St. Joseph's Health Centre Site

Specialized Rehabilitation and Complex Continuing Care: West Park Healthcare Centre

Primary Care: Four Villages Community Health Centre, Crosstown Family Health Team, Village Family Health Team, Stonegate Community Health Centre, LAMP Community Health Centre

Community Services: Reconnect Community Health Services (Mental Health & Addictions Services/Community Support Services), Regeneration Community Services (MH&A/CSS), Storefront Humber Inc. (Community Services), West Park Healthcare Centre (Seniors Mental Health)

Long-Term Care: West Park Long-Term Care Home Palliative Care: The Dorothy Ley Hospice

All members of the West Toronto OHT have demonstrated a history of formally and informally working with one another to advance integrated care, through the development of an integrated COPD pathway, West Community Connect, TC LHIN Long-Term Vent Strategy and West Toronto Primary Care Strategy. Some of these initiatives have included formal agreements in the form of MOUs, as well as commitments to integrated QIPs between organizations. Through this history, members have built trust and are willing to move forward in this next phase of integration. Further, the group is committed to expanding to include new members, to meet the care needs of West Toronto.

The team has actively engaged with other members of the Toronto West community in order to work towards designing a collaborative and integrated care network. At this time, the following organizations are supporting this submission and may be potential future members including: TC LHIN West Toronto Primary Care Lead, and Home & Community Care; Toronto Public Health; Progress Place; St. Michael's Homes; Weston Family Health Organization; Anishnawbe Health Toronto; Cota; West Toronto Support Services; Parkdale Activity Recreation Centre; Nurse Next Door Professional Home Care Services Inc.; Bellwoods Community Services; LOFT Community Services; GTA Rehab Network; PACE Independent Living, RNAO

Commitment to collaborate with others

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

Commitment to the Ontario Health Team vision

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

Part II: Self-Assessment Scoring

Model Component 1: Patient Care and Experience

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

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

Self-Assessment Scale for Patient Care and Experience

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

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

Your team is able to meet all of the requirements above

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

We are committed to expanding on our current integrative activities to arrive at a future state where all patients experience seamless care across and between each of our partner organizations, working together as a team.

Our team is able to identify opportunities and targets, as well as propose a plan for improving access, transitions, and coordination of care because of the work that has been underway in the West Sub Region for the past 18 months. Most members already have a history of working together on integrating care for patients within West Toronto.

Examples:

-Population-based Integrated Pathway for COPD care in West Toronto designed with a focus on meeting the community's health needs and improving coordination and integration across a COPD's care continuum (including partners such as Stonegate CHC, Four Villages CHC, West Park, St. Joseph Hospital, Toronto Public Health and the Toronto Central LHIN). Please see Appendix 2.

-West Toronto Connect ensures people living in the West Sub-Region of TC LHIN have a single point of access to community-based health service (connecting 28 health service providers). Please see Appendix 3.

- West Toronto Primary Care Strategy which includes advocating for patients, and for those with difficulty accessing the health care system (particularly those who are marginalized). Please see Appendix 4.

Given our experience, we are able to quantify the capacity needed in order to expand our efforts across additional providers and serving more patients in Year 1.

Model Component 2: *Patient Partnership & Community Engagement*

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

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

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

• If your team is proposing to be responsible for geography that includes one or more First Nation[2] communities you will be able to demonstrate support or permission of those communities	☐	☐	N/A

Self-Assessment Scale for Patient Partnership & Community Engagement

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

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

Your team is able to meet all of the requirements above

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

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

All members of our West Toronto team have a deep commitment to, and established history of, patient partnership and community engagement. As members of the group have engaged over the past 18 months, patient and family engagement has been included as a vital component to priority setting and service delivery redesign.

There are varied approaches to patient and community engagement across our members. Many members have established Patient Family Advisory Councils, included patient and family representation on Board committees, hiring committees and working groups, and conducted community-wide engagement sessions. Our work going forward will include the development of a joint patient and community engagement framework and strategy which will aim to harmonize approaches to engagement informed by best practices and the lived experience of approaches currently in place.

A number of our team members regularly engage in standardized patient and family satisfaction surveys in order to develop, inform and evaluate services and engagement activities for our organizations.

Based on existing engagement activities of the team, we are confident that we are able to meaningfully include patients, families and the community in the development of a full OHT application, should we be invited.

Members of our team adhere to the requirements of the French Language Services Act. Within our geography there are no identified First Nation Communities, however, a small proportion of residents identify as indigenous (Toronto's Indigenous strategy indicates that 1.3-2.7% of Toronto's population are Indigenous). We recognize the need for culturally safe, indigenous led services for the urban indigenous community in West Toronto. We are in discussions with Anishnawbe Health Toronto to be part of the OHT, and to collaborate to ensure we meet this need.

Model Component 3: Defined Patient Population

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

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

Self-Assessment Scale for Defined Patient Population

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

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

Your team is able to meet all of the requirements above

Rationale (300 words maximum)

Please provide a rationale for your self assessment response.
In addition, please include in your response:

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

At maturity, the West Toronto OHT will be providing healthcare services to a population beyond the boarders currently outlined as the West Sub-Region of the TC LHIN. This is based on our review of catchment areas of patients utilizing our collective services. This expanded region is bounded by Lawrence Ave. W. to the North, Ossington Ave. to the East, Lake Ontario to the South, and the Etobicoke Creek to the West (a map of the West Toronto OHT boundaries can be seen in Appendix 5). Utilizing the Ontario Community Health Profiles Partnership database (OCHPP), we estimate this population to be 527,000.

As an initial data source of relevant population health data at this time, we will refer to data available for the TC LHIN West Sub-Region as per Appendix 6 (pop. of 245,000). We recognize however that an immediate priority will be to obtain additional population health data aligned to our expanded catchment area.

Demographics:
-15% over 65 years of age; 37% immigrants; 81% speaks English or French at home
In comparison to the TC LHIN population, West Toronto has higher rates of:
-Mental Health and Addiction-related visits; High Blood Pressure
ALC:
-West Toronto compared to TC LHIN: High; West Toronto's % ALC: 17.7%

Given the above outlining significant prevalence of those living Mental Health and Addictions issues, chronic disease and high ALC rates, our target population for Year one will include:
-People with mental health and addiction needs;
-People with chronic disease, with a focus on COPD in Year 1;
-Frail seniors.

The selected priority population for Year 1 was chosen as it builds on significant integrative efforts that are currently underway with respect to mental health and COPD in West Toronto. The team has also established a commitment to align existing resources within West Toronto to support frail seniors in our community.

In Year 1, patients in these groups will be identified using systems already in place at member organizations. Future work will include the identification and implementation of a single system to roster patients across West Toronto.

Please refer to Appendix 6 with regards to the data noted above. As per Appendix 5, it is important to recognize that the West Toronto team is seeking to provide services beyond the borders of the TC LHIN West Sub-region as it is delineated in Appendix 6.

Model Component 4: In Scope Services

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

Assess your team's ability to meet the following requirements:	Yes	No	Partial
• Your team is able to deliver coordinated services across at least three sectors of care[3] and you have adequate service delivery capacity within your team to serve the care needs of your proposed Year 1 target population (e.g., your team includes enough primary care physicians to care for all Year 1 patients)	☐	☐	☒
• You are able to propose a plan for phasing in the full continuum of care over time, including explicit identification of further partners for inclusion	☐	☐	☒
• As part of that plan, you can specifically propose an approach for expanding your team's primary care services to meet population need at maturity	☒	☐	N/A

Self-Assessment Scale for In Scope Services

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

☐ ☐ ☐ ☐ ☐ ☒ ☐ ☐ ☐ ☐

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

Your team is able to meet all of the requirements above

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

Rationale (300 words maximum)

Please provide a rationale for your self assessment response.

For Year 1, specific to COPD we will solidify and expand services provided through an existing integrated COPD pathway as outlined in Appendix 4. Our Year 1 target, through this pathway is that 80% of patients admitted with acute exacerbation of COPD discharged from SJHC will not re-visit ED for acute exacerbations of COPD within 30 days of discharge from acute care.

Specific to MH&A and CSS, we will expand access to services through West Toronto Community Network of Care, an initiative to ensure that people living in our region have a single point of access to community-based health services. This will be enabled through a local access "hub" that virtually connects all existing community-based services within the Network, supporting quick and seamless transitions for patients from acute care and primary care to community-based healthcare (Appendix 3).

Regarding care for Frail Senior, we will bring together existing resources in the west such as West Toronto Primary Care Strategy, which is the integration of care navigation and information sharing.

In Year 1, we are deeply motivated to advance the optimal use of virtual solutions (such as SCOPE, SPIN, etc.) and the use of Nurse Practitioners in order to appropriately meet the primary care need of residents. The team is also seeking opportunities to further incorporate Care Coordinators/Navigators for the West Toronto sub-region, and recognize their important role in the patient's care journey.

Overall, the West Toronto OHT is able to provide a broad range of services across the continuum of care from health promotion, to diagnosis, through to palliative and end of life care through the integration of our resources. Midwifery services will be integrated in year 2.

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

primary care
- ☒ interprofessional primary care
- ☒ physicians

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

Individuals and Caregivers (Reconnect Community Health Services), Health Education & Health Promotion (Village FHT, Crosstown FHT, Four Villages CHC, LAMP)

Ontario Health Team
Self-Assessment Form

Model Component 5: Leadership, Accountability and Governance

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

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

Self-Assessment Scale for Leadership, Accountability and Governance

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

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

Your team is able to meet all of the requirements above

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

All members of the West Toronto OHT have demonstrated a history of formally and informally working with one another to advance integrated care, through the development of an integrated COPD pathway, West Community Connect, TC LHIN Long-Term Vent Strategy and the West Toronto Primary Care Strategy . Some of these initiatives have included formal agreements in the form of MOUs, as well as commitments to integrated QIPs between organizations.

Through this history, members have built trust and are willing to move forward in this next phase of integration. Further, the group is committed to expanding to include new members, to meet the care needs of West Toronto.

Over the past 18 months, the participation of the West Toronto Primary Care Lead has been instrumental in working towards integration in West Toronto. The interdisciplinary nature of our team allows us to include members from across the care continuum in designing and operationalizing a governance and leadership model that meets the needs of patients and providers in all care settings from primary care practices and family health teams to community and acute organizations.

As we progress towards maturity, the team is committed to working towards necessary formal agreements and governance structures that include:

-Patient and/or family advisors
-Physician and clinical leaders are to be included as part of the leadership and/or governance structure
-A structure conducive to coordinated care delivery, support achievement of performance targets, and enable achievement of accountability objectives
-A central brand
-Formal agreement(s) and reporting obligations

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

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

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

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

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

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

Your team is able to meet all of the requirements above

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

Rationale (250 words maximum)

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

Each member of our OHT has a demonstrated history of quality and performance improvement, for example through our formal Quality Improvement Plans (QIPs).

Our team is committed to creating a joint quality improvement plan, using indicators demonstrating our effectiveness as integrated service providers including:
-ED visits and readmission rates from home and community care clients
-Inappropriate bed assignments (ad-hoc/non-conventional spaces)
-Primary care follow-up within 7 days post-discharge
-30 day readmission rates for chronic conditions
-ALC days from ALC designation to discharge, by discharge destination
-Patient/caregiver experience

West Sub-Region-specific baseline indicators along with specified data sources have been utilized by many team members for various projects and supports the identification and tracking of shared indicators.

We understand the importance of providing high quality care across a patient's care journey from primary care and community services, to acute organizations, to post-acute rehabilitation. Through the development of a Performance Measurement and Quality Sub-Committee, key quality metrics from organizations will be brought forth and analyzed in order to determine cohesive metrics and indicators across the team.

We recognize that in order to deliver integrated care, this will require a shift from organization-specific to OHT-wide performance measures, which the West Toronto team is committed to working towards.

As an additional value proposition, researchers from the Centre for Urban Health Solutions at Unity Health (i.e., St. Joseph's) will be engaged from an advanced research and evaluation perspective. We will also leverage the Community Impact Assessment model used by some of our partners.

Model Component 7: Funding and Incentive Structure

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

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

Self-Assessment Scale for Funding and Incentive Structure

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

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

Your team is able to meet all of the requirements above

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

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

We are proud to report that each member of the team is able to demonstrate a strong track record of responsible financial management. In addition, we have members involved in bundled care and experience with cross-provider and cross-sector funding.

Many members of the team have advanced financial analytic capabilities including case costing, as well as experience at a provincial level determining methodologies for bundled payment, and prices for QBPs. As a result, our team is well equipped and has more than a basic understanding of the costs and associated drivers of care.

The team is knowledgeable of unique funding mechanisms across care types (acute, rehabilitation, primary care, FHT, CHC, CSS, etc.) and is committed to proceeding towards an integrated funding envelope. As an immediate next step, we will be seeking to improve our collective understanding of costs with an emphasis on costs across community-based services. Recognizing the potential risk to the operations/integrity of any individual organization in this environment, we look forward to working with the Ministry and other OHTs to develop appropriate allocation methodologies to mitigate that risk.

Model Component 8: Digital Health

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

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

Self-Assessment Scale for Digital Health

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

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

Your team is able to meet all of the requirements above

Rationale (250 words maximum)

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

All members of the team have digital health capabilities to access and share health information among members of patients' circle of care alongside leveraging technology to enhance models of patient care delivery. Members have implemented various digital solutions (private and provincial assets) in order to collect, use and share information to patients and providers. Examples of solutions used by team members include:

-ONE MAIL
-E-Consult
-Connecting Ontario
-RM&R
-Caredove
-eCCP
-HRM
-MyChart
-OLIS
-CHRIS
-Integrated Assessment Record (IAR)

Please refer to Appendix 7 for further details on the solutions above.

A number of members are using electronic tools to support patient care virtually and provide access to health data via patient portals. Decision support capability is present in most organizations, with the ability to scale to other team members. Often this capability is supported through business intelligence platforms again, with the ability to scale.

The team recognizes that in the early stages, concentrated effort and resources will be required to implement and improve the interoperability of many of the solutions identified above.

Part III: Implementation Snapshot

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

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

Following West Toronto's OHT submission on May 15, next steps will be taken to continue collaboration among health service providers in West Toronto:
-Community agency engagement and co-design (engagement sessions scheduled for end of May)
-Physician, patient, families, clients engagements
-In-depth data analysis to understand population needs, service capacity assessment, costs and distribution models
-Establish governance structure with MoU
-Continued partnerships among health service providers around bundled care for specific procedures
-Continued development of integration with primary care, leveraging the work being completed through the West Toronto Primary Care strategy

Recognizing the tremendous amount of work that is either currently being planned or already underway for our target populations, in Year 1 our goal would be to implement an integrated structure for managing, expanding and evaluating these various initiatives across our OHT.

Primarily themed under the concept of increasing capacity within primary care to better address our population's health needs, below are specific initiatives aligned to each of our Year 1 target groups:

1. Mental Health & Addictions and Community Support Services (MH&A/CSS)
-Implementation of West Community Connect as a single point of access to mental health, addictions and community support services (Appendix 3).
-Scaling-up Integrated Mental Health Care (IMHC) to improve access to psychiatric services within primary care

2. Frail Seniors
-West Toronto OHT members have initiated discussions based on expanded access to geriatric specialty services (such as geriatric consultations, home assessments etc.) and home-based care

3. COPD
-Continued implementation of the population-based integrated model of care for COPD whereby partner organizations are focus on meeting the community's health needs and improving coordination and integration across a COPD's care continuum (Appendix 2)

Finally, as a key initiative underpinning much of the work above, we will be supporting further integration of Care Coordinators with primary care and other community service providers, via the alignment of catchment areas of approx. 35 care coordinators/provider organizations to the 15 City of Toronto neighbourhoods in the West Toronto Sub-region (see Appendix 8).Year 1 focus on South Parkdale and Roncesvalles as the highest priority neighbourhoods starting with designated Toronto Community Housing sites.

Part IV: Sign Off

Proposed name of the Ontario Health Team	West Toronto Ontario Health Team
Primary contact for this application	**Name:** Jan Walker
	Title: VP Strategy, Innovation and CIO
	Organization: West Park Healthcare Centre
	Email: jan.walker@westpark.org
	Phone: 416-243-3600 ext. 2124

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

Endorsed by	
Name	
Position	
Organization	
Signature	
Date	

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Please repeat signature lines as necessary

Ontario Health Team
Self-Assessment Form

Part IV: Sign Off

Proposed name of the Ontario Health Team	
Primary contact for this application	Name:
	Title:
	Organization:
	Email:
	Phone:

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Endorsed by	
Name	Jennifer Bowman
Position	VP People and Transformation
Organization	Unity Health Toronto (for St. Joseph's Health Centre)
Signature	J Bowman
Date	May 14, 2019

Endorsed by	
Name	
Position	
Organization	
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Date	

Please repeat signature lines as necessary

Ontario Health Team
Self-Assessment Form

Part IV: Sign Off

Proposed name of the Ontario Health Team	
Primary contact for this application	Name:
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	Organization:
	Email:
	Phone:

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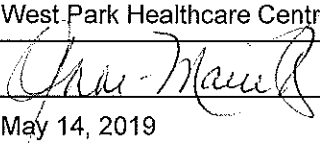
Endorsed by	
Name	Anne-Marie Malek
Position	President and Chief Executive Officer
Organization	West Park Healthcare Centre
Signature	
Date	May 14, 2019

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Ontario Health Team
Self-Assessment Form

Part IV: Sign Off

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Primary contact for this application	**Name:**
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	Organization:
	Email:
	Phone:

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Endorsed by	
Name	Gillian Bone
Position	Deputy CEO
Organization	The Four Villages Community Health Centre
Signature	
Date	13 May 2019

Endorsed by	
Name	
Position	
Organization	
Signature	
Date	

Please repeat signature lines as necessary

Ontario Health Team
Self-Assessment Form

Part IV: Sign Off

Proposed name of the Ontario Health Team	
Primary contact for this application	Name:
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	Organization:
	Email:
	Phone:

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Endorsed by	
Name	Kate Malisani
Position	Executive Director
Organization	Crosstown Family Health Team
Signature	
Date	May 13 2019

Endorsed by	
Name	
Position	
Organization	
Signature	
Date	

Please repeat signature lines as necessary

Ontario Health Team
Self-Assessment Form

Part IV: Sign Off

Proposed name of the Ontario Health Team	
Primary contact for this application	Name: West Toronto
	Title:
	Organization:
	Email:
	Phone:

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Endorsed by	
Name	Dr. David Verrilli
Position	Board vice chair and FHO Lead Physician
Organization	Village Family Health Team
Signature	D Verrilli
Date	10 MAY 2019

Endorsed by	
Name	
Position	
Organization	
Signature	
Date	

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Ontario Health Team
Self-Assessment Form

Part IV: Sign Off

Proposed name of the Ontario Health Team	
Primary contact for this application	Name:
	Title:
	Organization:
	Email:
	Phone:

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Endorsed by	
Name	Bev Leaver
Position	Executive Director
Organization	Stonegate Community Health Centre
Signature	Beverly Leaver
Date	May 15, 2019

Endorsed by	
Name	
Position	
Organization	
Signature	
Date	

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Ontario Health Team
Self-Assessment Form

Part IV: Sign Off

Proposed name of the Ontario Health Team	
Primary contact for this application	**Name:**
	Title:
	Organization:
	Email:
	Phone:

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Endorsed by	
Name	KEDDONE DIAS
Position	EXECUTIVE DIRECTOR
Organization	LAMP COMMUNITY HEALTH CENTRE
Signature	
Date	MAY 14, 2019

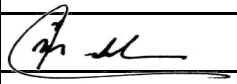
Endorsed by	
Name	
Position	
Organization	
Signature	
Date	

Please repeat signature lines as necessary

Part IV: Sign Off

Proposed name of the Ontario Health Team	
Primary contact for this application	**Name:** Mohamed Badsha
	Title: Chief Executive Officer
	Organization: Reconnect CHS
	Email: mbadsha@reconnect.on.ca
	Phone: (416) 558-6891

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

Endorsed by	
Name	Mohamed Badsha
Position	Chief Executive Officer
Organization	Reconnect Community Health Services
Signature	
Date	05/13/2019

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Part IV: Sign Off

Proposed name of the Ontario Health Team	
Primary contact for this application	Name:
	Title:
	Organization:
	Email:
	Phone:

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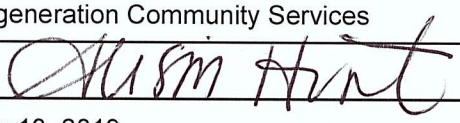
Endorsed by	
Name	Alison Hunt
Position	Executive Director
Organization	Regeneration Community Services
Signature	
Date	May 13, 2019

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Ontario Health Team
Self-Assessment Form

Part IV: Sign Off

Proposed name of the Ontario Health Team	West Toronto OHT
Primary contact for this application	Name:
	Title:
	Organization:
	Email:
	Phone:

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

Endorsed by	
Name	Dipti Purbhoo
Position	Executive Director
Organization	The Dorothy Ley Hospice
Signature	Dipti Purbhoo
Date	May 9, 2019

Endorsed by	
Name	
Position	
Organization	
Signature	
Date	

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Ontario Health Team
Self-Assessment Form

Part IV: Sign Off

Proposed name of the Ontario Health Team	
Primary contact for this application	Name:
	Title:
	Organization:
	Email:
	Phone:

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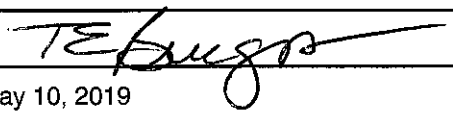
Endorsed by	
Name	Thomas Burger
Position	Executive Director
Organization	Storefront Humber Inc.
Signature	
Date	May 10, 2019

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Appendix 1:
West Toronto OHT May 15th Self-Assessment Submission Members

Type	Organization
Hospital	St. Joseph's Health Centre
Specialized Rehabilitation, Complex Continuing Care, and Long-term Care	West Park Healthcare Centre
Primary Care	Four Villages Community Health Centre
	Crosstown Family Health Team
	Village Family Health Team
	Stonegate Community Health Centre
	LAMP Community Health Centre
Mental Health & Addictions Services (& Community Services)	Reconnect Community Health Services
	Regeneration Community Services
Community Services	Storefront Humber Inc.
Palliative Care	The Dorothy Ley Hospice

St. Joseph's Health Centre

Name:	St. Joseph's Health Centre
Type:	Hospital

Description:

- A Catholic community teaching hospital affiliated with the University of Toronto, and accredited with exemplary standing by Accreditation Canada, serving the communities of West Toronto
- 2,600 staff; 488 physicians; 440 volunteers; 1,000 students
- 426 beds; 22,289 admissions/year
- 3,275 births; 182,467 diagnostic imaging procedures; 26,565 surgical and procedural cases; 247,471 ambulatory care visits; 101,038 emergency department visits
- St. Joseph's Health Centre with Providence Healthcare and St. Michael's Hospital now operate under one corporate entity as of August 1, 2017

Services:

- Serving patient needs in areas such as Emergency Care, Medicine, Family Birthing, Surgery, and Mental Health
- Wide range of outpatient clinics to help support our patients' continuum of care once they are discharged home, including our seniors clinic, fracture clinic, diabetes and paedatric clinics
- Addictions Services; Adult Inpatient Mental Health; Cardiology; Child, Adolescent and Family Mental Health; Diagnostic Imaging; Dialysis – Regional Renal Program; Emergency Department; Family Birthing Centre; Family Medicine/Urban Family Health Team; Fracture and Orthopaedic Clinic; Intensive Care Unit; Laboratory Medicine Services; Medicine and Seniors Care; Neurology; Ontario Breast Screening Program; Outpatient Chemotherapy; Outpatient Clinics – Ambulatory Care Centre; Outpatient Mental Health; Outpatient Rehabilitation Service; Paediatrics; Pain Management and Anesthesia; Palliative Care; Pharmacy; Reactivation Care Centre; Respirology; Surgery

Patients:

- Emergency Room:
    - 79% of visits come from SJHC catchment
- Inpatient:
    - 71% of visits come from SJHC catchment
    - <2% come from SMH catchment

- Referral partners include: CCAC, Runnymede & TRI
- Outpatient:
  - 74% of visits come from SJHC catchment
  - 14% of visits come from broader Toronto
  - 6% of visits come from Peel

West Park Healthcare Centre

Name:	West Park Healthcare Centre
Type:	Rehab and Complex Continuing Care

Description:

West Park Healthcare Centre helps patients get their lives back by providing specialized rehabilitative and complex care after a life-altering illness or injury such as lung disease, amputation, stroke, and traumatic musculoskeletal injuries. West Park stands out among its peers as an important contributor to the healthcare sector providing specialized services at the local (based on the local population health needs), regional, and provincial levels. West Park is recognized as:

- Designated as Ontario's Provincial Centre of Excellence for Long Term Ventilation. It has the largest long term ventilation program in Ontario
- It has the ability to care for complex patients within CCC including those on ventilators and BiPap which most other peer facilities are unable to accommodate.
- It is a designated stroke centre for stroke rehabilitation.
- It is also one of 4 Acquired Brain Injury Behavioural Service providers in the Province and the only one within the Toronto Central LHIN.
- It is the largest provider of amputee rehabilitation in the Toronto Central LHIN and the Province in terms of volumes
- It is the designated provincial resource for Tuberculosis care with both in-patient and out-patient services, and the largest provider of in-patient Tuberculosis services in the Province.
- It treats the most inpatient COPD rehab cases in Ontario.
- A leading provider of spasticity treatment. West Park is leading the treatment of this overlooked condition from which individuals with strokes, cerebral palsy and multiple sclerosis suffer

West Park is in the midst of an important transformation with the development of a new hospital which aims to address gaps within the healthcare system and contribute to a sustainable healthcare for the future. The new hospital will bring together, on a single site specialized rehabilitation, complex continuing care, primary care, long-term care, clinical research and community-based services which would facilitate coordination of services across the continuum of care. Along with the development of the new hospital, is the non-hospital development which will provide a spectrum of programs and services (e.g. supportive housing, hospice, and community based- services) to support West Park's vision of an integrated campus of care.

Services:

- **Acquired Brain Injury Adult Day Program (Outpatient):** Helps individuals with acquired brain injuries enhance their strengths and learn new skills with the goal of living more independently
- **Acquired Brain Injury Community Outreach Service (Outpatient): Outreach** behavioural rehabilitation provided in clients' home for individuals with challenging behaviours and an acquired

brain injury.

- **Acquired Brain Injury Behaviour Service (In-Patient):** Collaborative, patient-driven and goal-oriented rehabilitation
- **Amputee Rehabilitation Service:** Helping those who have lost limbs rebuild their lives with courage and confidence.
- **CAVC Service (In-Patient):** Care for individuals needing invasive mechanical ventilation
- **Long-Term Ventilation Centre of Excellence (Outpatient):** Championing improvements in LTV
- **Complex Continuing Care (In-Patient):** Residential nursing care for people with special chronic care needs.
- **Enhanced Living Service (In-Patient):** Care and support for individuals needing invasive mechanical ventilation
- **Functional Enhancement Service (In-Patient): Helping** older adults improve their functional ability and quality of life after injury or stroke
- **Gage Transition to Independent Living (Residential):** Empowering those with physical disabilities to live independent lives.
- **Home Ventilator Training:** For people who need mechanical assistance to breathe.
- **Musculoskeletal Rehabilitation Service:** Rehabilitation for those recovering from bone, muscle or joint injury or surgery.
- **Neurological Rehabilitation Service (In-Patient):** In-patient rehabilitation for people facing the challenge of recovering from stroke or head injury.
- **Out-patient Clinics and Services (Outpatient):** Out-patient clinics for people who live in the community
- **Prosthetic and Orthotic Service:** Enabling individuals with limb amputations to live fuller, more independent lives.
- **Respiratory Continuing Care (In-Patient):** Residential respiratory care for people with chronic breathing disorders
- **Respiratory Day Hospital (Outpatient):** Helping individuals with chronic lung disease live independently in the community.
- **Geriatric Interprofessional Assessment Clinic:** Specializing in the Functional enhancement of older adults with complex medical and psychosocial issues and age-related changes
- **Seniors Mental Health Service:** Practical advice and information about mental health problems for seniors
- **Sleep Laboratory (Outpatient):** Specializing in studies on individuals with respiratory, cardiovascular or neurological conditions.
- **Spasticity Management Clinic (Outpatient):** Assessing and treating spasticity through an interprofessional team approach.
- **Specialty Clinic (In-Patient):** Clinics for West Park in-patients.
- **Tuberculosis Service:** Treating patients with complex tuberculosis to help them return safely to the community.
- **Transitional Home Ventilation (In-Patient):** Providing rehabilitation, training and education.

Patients:

- West Park has 130 rehabilitation and community living beds, 146 complex continuing care beds and 200 long-term care beds
- Though West Park is located in West Toronto, it acts as Ontario's Provincial Centre of Excellence for Long Term Ventilation and acts as a designated provincial resource for Tuberculosis with both in-patient and out-patient services

Other Information:

- **COPD Pathway Collaboration with**: St. Joseph Health Center, Stonegate Commuity Health Centre, 4 Village Community Health Centre and Crosstown Family Health Team

Four Village Community Health Centre

Name:	Four Villages Community Health Centre
Type:	Primary Care

Description:

- The Four Villages Community Health Centre actively improves population health in West Toronto. We provide inter-professional primary health care services and health promotion programs for over 7,000 clients.
- Together, our services and programs improve our clients' physical and mental health and help keep them independent in the community. We offer services to all residents in West Toronto, with a focus on seniors, families with young children (in particular newcomers) and youth.
- We are fully accredited, with two sites, and over 60 staff. Our health care team includes: chiropodists, clinical assistants, community health workers, dietitians, nurse practitioners, occupational therapist, physicians, physiotherapists, primary care coordinator, registered nurses, social workers and therapists.

Services:

- Comprehensive primary care services
- Four Villages offers a wide variety of programs for clients at both of our sites, and other locations in the community. Programs focus on:
  - nutrition, healthy eating, and access to healthy and affordable food
  - pain management, rehabilitation and getting active
  - maternal health, and early child development
  - mental health and addictions, recovery and wellness
- Programs for adults and seniors include: healthy eating workshops, diabetes education program, knitting groups, legal clinics, housing assistance program, pulmonary rehabilitation, GLA:D – Hip and Knee osteoarthritis rehabilitation, seniors exercise programs, walking programs, yoga
- Programs for parents, families and children include: prenatal health program, kids cooking club, parenting support groups, toddler parenting workshops, school outreach
- Programs for youth include a youth cooking club, tutoring

Patients:

- Four Villages Community Health Centre serves West Toronto, our catchment includes the neighbourhoods of South Parkdale, Roncesvalles, High Park North, Runnymede-Bloor West Village, Junction Area, Lambton Baby Point and parts of Rockcliffe-Smythe and Mount Dennis
- 5,800 clients received inter-professional team based care in 2018/19

Other Information:

- Lead HSP for TC LHIN Primary Care Community Rehabilitation Network
- Co-lead in the West Toronto West End Collaboration Initiative (Access to Care QI collaborative between 6 CHCs)
- Integrated back office service provider with Storefront Humber and Regeneration House

Crosstown Family Health Team

Name:	Crosstown Family Health Team
Type:	Primary Care

Description:

- Provides primary care and interdisciplinary health care, including social work, nursing, physiotherapy, dietary, and pharmacist services with the goal of providing comprehensive primary care

Services:

Focus on self-management strategies and learning; offerings include some one-on-one counselling with the IHPs as well as group workshops which include

- Craving Change-mindful eating habits (basis in CBT)
- Why Weight?-mindful weight loss
- CBT for Anxiety- CBT based workshops for anxiety and depression
- Smoking Cessation-stop smoking sessions
- Perfectionist Thinking-workshop for anxiety and perfectionist thinking
- Health Awareness-variety of topic

Other services include:

- System navigation for complex patient population
- Diabetes management
- Cancer Screening efforts
- Spirometry program
- Physiotherapy and physiotherapy-based self-management programs for common concerns (low back pain, chronic pain management)

Patients:

- 4,000 rostered patients, over 1,000 non-rostered patients (2 physicians currently accepting new patients)
- Significant rates of mental health (12%), CVD (15%), chronic pain, diabetes (10%)

Other Information:

- **COPD Collaboration:** working with West Park Health Centre, St. Joseph Health Center, Stonegate Community Health Centre and Four Village Community Health Centre to provide community-based COPD education

Village Family Health Team

Name:	Village Family Health Team
Type:	Primary Care

Description:

- Village FHT was incubated by Centre for Addiction and Mental Health (CAMH) (and continues to work in close collaboration with CAMH) as a place for people with serious mental health illness to receive high quality primary care
- Village FHT opened in Liberty Village in 2012 and has grown to over 10,500 patients
- The clinical team includes: 10 family physicians, 1 nurse practitioner, 2.5 RNs, 1 MSW, 1 Medical Assistant, 1 part-time addictions counselor, chiropodist, pharmacist, registered dietician and access to physiotherapy via Parkdale CHC, 1 day/week on-site psychiatrist

Services:

Services tailored towards providing primary care to people with serious mental illness, some examples include:

- On site blood work for those facing barriers to going to a community lab
- Standard30-minuteappointments with MDs
- Secure communication capability with case workers and others supporting people
- Home visits as needed including MDs and any member of the team. This includes supportive housing sites such as John Gibson House, St Anne's Place etc
- Metabolic program for people with diabetes and SMI(usually schizophrenia)
- COPD program including on-site spirometry. Majority of our patients with COPD also have SMI
- Focus on effective communication for those with very low literacy abilities
- -Antipsychotic medication management (both oral and injection) for 40 patients. The family physician manages the medication(i.e.not a psychiatrist)
- Integrated Care Pathway for Major Depressive Disorder in collaboration with CAMH
- On site CBT and DBT offered by Village and CAMH therapists mild to moderate and severe depression and anxiety
- Psychiatry on site to support shared care management of people with serious mental illness
- Addictions Medicine for a range of addictions. Includes prescribing Suboxone combined with on-site counselling for Village FHT patients and others referred through SPIN

Patients:

- 20% of Village FHT patients have a diagnosis of serious mental health illness or addictions (SMI), balance of patients are generally young professionals with children;
- ~500 patients <2 yrs, 1000 patience <4 yrs old, very few older adults >80 yrs or teenage patients

Other Information:

- Cancer screening rates higher than provincial average
- Hospitalization for chronic medical conditions (COPD, CHF, Diabetes) lower than, or at provincial average
- Consistent same day/next day access to care

Stonegate Community Health Centre

Name:	Stonegate Community Health Centre
Type:	Primary Care

Description:

- Serves south and central Etobicoke, and provides primary care for all ages
- Care team includes: physicians, nurse practitioner, nurses, a dietician, a chiropodist, a certified respiratory education, mental health counselors, health promoters, and an early childhood educators; through partnerships they are able to offer a full dental team, occupational therapy, diabetes education, legal services and settlement services

Services:

- General Primary Care Services
- Group Programs: prenatal and postnatal programs, early years programs, school readiness, afterschool programs, seniors programs, nutritional and physical activity programming
- Chronic Disease Management Programs: mental health programming, physical rehabilitation programs
- Primary Care Asthma Program
- Homlessness prevention
- Smoking Cessation with free nicotine replacement therapy
- Healthy Smiles Dental Clinic
- FoodFit-12-week program community members living a limited budget, who are motivated to make

lasting changes to their health
- GLA:D- Hip and Knee Osteoarthritis rehabilitation
- Pulmonary Rehabilitation
- Caregiver Support Groups- Living Life to the Full
- Weekly food markets

Patients:
- Serves south and Central Etobicoke
- 5,700 active clients (85% reside in Etobicoke, 5% reside in Mississauga, balance residing in west Toronto).
- 18% of clients aged 65+
- 63.5% of rostered primary care clients have incomes in the lowest two income quintiles
- 33.5% of clients are recent immigrants

LAMP Community Health Centre

Name:	LAMP Community Health Centre
Type:	Primary Care

Description:
- Serves communities of South Etobicoke, Central Etobicoke, and East Mississauga **(All service information provided below is specific to Etobicoke)**
- LAMP Community Health Centre strives to improve quality of life in our communities by supporting people to reach their fullest potential. We do this by working in partnership with our communities to address new and emerging community needs. LAMP supports a wide-range of community programs, health care services, and advocacy initiatives that promote the physical, emotional, mental, ethno-cultural, social and economic well-being of our communities.

Services:

· **CLINICAL HEALTH SERVICES –**
- **Primary Health Care** - Our team consists of 4 Family Physicians, 3 Nurse Practitioners, a Registered Practical Nurse, Medical Office Assistants, and an Administrative Supervisor.
- **Social Work** - The social worker provides counselling, case management and advocacy to LAMP clients in our service area. We also provide the same service to clients of solo practitioners within our service area.
- **West Toronto Diabetes Education Program** - West Toronto DEP is a comprehensive Diabetes Education Program that has been in operation since 2002. West Toronto DEP is a division of LAMP Community Health Centre (CHC) and is in partnership with leading CHC's to provide timely, safe, and client centered care.
- **Occupational Health** - The LAMP Occupational Health Centre is a specialized service conducting health assessments for work-related health problems, assistance with Workplace Safety and Insurance Board (WSIB) claims and occupational health educational information.
- **Chiropody** - The foot clinic offers a full range of clinical services to address foot and foot related concerns. These might include nail conditions, corns, callus, warts, ulcerations, and pain. We provide preventative care for health conditions such as diabetes.
- **Physiotherapy** - The Physiotherapy Program currently provides injury prevention programs, direct assessment and treatment, education, support programs and group programming for clients of the LAMP Community Health Centre and the South Etobicoke area.
- **We also offer Smoking Cessation, Asthma Clinic, and an Opioid Replacement Therapy Clinic**

COMMUNITY HEALTH SERVICES –

- **EarlyON Child and Family Services** - The LAMP Early ON Child & Family Services programs offer FREE drop-in play programs for parents and caregivers and their children (birth to 6 years old). The programs are available to all families at 7 different locations across South Etobicoke.
- **Adult Learning**- We serve clients who are at least 19 years old and are out of school, and want to upgrade their reading, writing, math, or computer skills. Learners must be fluent in spoken English and able to commit to 3 hours of learning each week for at least 6 months to 1 year.
- **Harm Reduction** - The services provided through the drop in include regular street outreach, supply distribution, kit making, safe disposal of supplies, condom distribution, sex worker supports, as well as drug and drug use information.
- **Among Friends** - Among Friends is a Community Mental Health Program for adults aged 18-65. Focused on fun and mental health promotion, "The Culture of Recovery" guides our daily programs.
- **Adult drop-in** - The Adult Drop-in offers a safe, welcoming space for homeless and street involved individuals and socially isolated adults.
- **Health Promotion –** personal development groups, community education, advocacy, community identified initiatives, research, intersectoral collaboration.
- **ASK! Community Information –** Information, Referral and Advocacy, Legal Information and Advice Clinics, True Copy and Commissioner for Taking Affidavits Clinic, Immigrant Settlement Services for Newcomers to Canada, Government Form Filling, Income Tax Clinic
- **Youth Programs** – Rathburn Area Youth, Street Level Youth, and SEYA programs focused on youth engagement, empowerment, and leadership

Patients:

LAMP Community Health Centre serves the communities of South Etobicoke where we provide all services listed above. Our catchment area for our Lakeshore services is). LAMPs catchment is Etobicoke Creek to the west, Queensway to the North, Humber River to the east, and the Lake to the south.

East Mississauga catchment – Hurontario to the west, Etobicoke Creek to the east, Matheson to the north, and the laketo the south.

Reconnect Community Health Services

Name:	Reconnect Community Health Services
Type:	Mental Health & Addictions Services (& Community Services)

Description:

- Reconnect offers a wide range of programs, treatment, and support to individuals and their caregivers who are dealing with acute and chronic age-related challenges, mental illness and addictions concerns, and are doing so with minimal supports. In 18/19, Reconnect served over 7000 clients living in the west end of Toronto and it's surrounding neighborhoods.
- Boundaries of Service:
    - Reconnect provides services in the West End of the City of Toronto
    - Most services are provided West of Yonge Street, North to Eglington Avenue, South to the Lake and West to Islington Avenue
    - Additionally, some services are provided in the Rexdale area of the Central West LHIN as well as in Peel Region.

Services:

- **Health Services:** A full continuum of specialized and intensive mental health, addiction and seniors'

services using a comprehensive range of clinical experience and expertise. This includes 3 multi-disciplinary teams, Intensive Case Management Services, Crisis Services for Seniors and Addictions Services for Seniors, Homeless Services, Forensic Services and a Short-term Crisis Residential Facility for people with mental illness and criminal justice issues.

- **Community Services:** Offers a range of services and programs which allow individuals to age at home with dignity and continuing independence. This includes Adult Day Services, Case Management, Community Programs, Home Help and Personal Care, Meals on Wheels, Older Adult Centre, Respite Care, Supportive Housing, Therapeutic Falls Prevention and Exercise, and Transportation.
- **Family Support Services:** Reconnect's Family Support Services offer a range of supports to family members and caregivers who provide support to individuals experiencing a mental health concern. Services include drop-in support groups, one-on-one counselling and specialized programming for children and youth.

Patients:

- Reconnect serves seniors, caregivers, and people living with mental health and addictions concerns. The organization serves individuals from the age of 7 years and upwards. Most services are provided to adults and seniors.
- A large proportion of Reconnect's clients experience poverty, marginalization and are at risk of homelessness. 2 out of 3 clients (66%) live below the poverty line.
- Many are seniors and have complex health issues and disabilities along with serious mental health and addictions needs.
- 40% of our clients are immigrants.
- 85% of our clients live alone.
- In addition to a mental illness, 1 in every 3 (35%) clients has a chronic illness, 1 in every 4 (20%) has a physical disability, and 1 in every 5 (25%) has a drug or alcohol dependence
- Where patients come from:
    - Reconnect serves West Toronto and Mid-West Toronto sub-regions in the Toronto Central LHIN. Many neighborhoods in these sub-regions have a high number of seniors and among the largest populations of residents over 85 as well as disadvantaged neighbourhoods with growing newcomer populations such as Mount Dennis and Rockcliffe-Smythe. The communities the agency serves range from very affluent to those with a high proportion of low income and vulnerable populations.
    - Most of our referrals come from hospital (general and psychiatric) and other community agencies. The justice system (police, courts, diversion, correctional facilities) related referrals are the next highest referral source, third would be self-referral (includes family, friend, neighbor), and other common sources include primary care and housing supports.
    - 50% of all our clients live in West Toronto; 33% of all our clients live in the west sub region

Other Information:

- Reconnect leads and will be the intake hub for the West Toronto Network of Community Care – which provides centralized access to all community health services in the West Sub Region
- Reconnect is a sub region lead in the West Sub Region
- Reconnect led the Integrated Community Care process for the TC LHIN
- Reconnect served as the lead agency for the Central West Toronto Health Link.
- Reconnect provides project management, IT and IM support for community agencies in the TC LHIN through:
    - Community Business Intelligence
    - Community Information Management

○ Community Shared Services: professional procurement support for community agencies

Regeneration Community Services

Name:	Regeneration Community Services
Type:	Mental Health & Addictions Services (& Community Services)
Description: • Regeneration Community Services provides supportive housing and support to individuals with complex and serious mental health and/or addictions	
Services: • **Case Management:** empower client-members to achieve their goals and connecting them with supports and resources in the community • **Peer Support Workers:** utilize their lived experience within the mental health community to support and mentor client-members through their own personal journey of recovery • **Residential Support Workers (for housing tenants):** provide practical assistance to address the physical, cognitive, mental health and addictions needs of client-members, supporting them in daily living and household activities. Regeneration offers a range of support levels for supportive housing from independent living to 24 hour/365 day on site staff support in congregate/shared living for individuals with complex health care needs. Regeneration has specialty services in providing high support supportive housing and a managed alcohol program for individuals with long histories of non-beverage alcohol use. Regeneration provides affordable and supportive housing to approximately 350 individuals.	
Patients: • Offers services to clients throughout Toronto, however majority of services are in west Toronto (primarily in the Parkdale area) • Referrals received directly from CAMH, Seaton House, Community partners like Breakaway Addiction Services, Toronto Community Addiction Team and The Access Point (a coordinated access hub for mental health and addictions where the public can apply for service).	
Other Information: • Regeneration owns 8 properties (to provide service or housing) in the Parkdale area	

Storefront Humber

Name:	Storefront Humber
Type:	Community Services
Description: • Major provider of community personal support and home help in East Mississauga and West Toronto • Founded in 1971 years ago in West Toronto to assist a marginalized population of seniors and adults with disabilities • Storefront Humber is a designated health service provider accountable to the Toronto Central LHIN and Mississauga-Halton LHIN	
Services: • **Supportive Program:** Support with personal care and homemaking to seniors to allow them to remain independent in their own home. The care is offered episodically for short intervals throughout the day with an allotted time of 1.5 hrs of care per day. Support includes such activities as assistance with bathing, dressing and other personal care, light meal preparation, medication reminders, light housekeeping and laundry. 186 clients have been served with a total of 686 PSW hours.	

- **Personal Support Services:** Personal support workers assist clients with personal care in order to support their living independently in their home. Personal support workers assist clients with such activities as bathing, dressing, light meal preparation and medication reminders. Care is provided in the client's home with special modifications made if required. 653 clients have been served with a total of 90,000 PSW hours.
- **Homemaking Services:** Home care workers assist seniors with light housekeeping. They are available to do dusting, vacuuming, washing floors, cleaning bathrooms and kitchens, changing bedding and laundry. They may also assist with shopping provided the shopping is within walking distance. 510 clients have been served with a total of 15,000 worker hours
- **Respite Services:** offers temporary care in the home for seniors in order to provide a brief period of relief or rest for the family members, guardians or other people who are their regular caregivers. It offers the caregiver relief from the constantly demanding responsibility of providing care. The service provides appropriate care and supervision to protect the client's safety in the absence of the caregiver. 65 clients have been served with a total of 10,000 PSW hours
- **Well Elderly Program:** supports seniors in the community, encouraging socialization and minimizing social isolation. The program offers a variety of activities that encourage healthy living and socializing opportunities. Examples of activities include gentle fitness, day trips, attending concerts and celebrating special holidays. Shopping trips are provided weekly in which the clients are bused to a local grocery store and assisted with grocery shopping. 333 clients have been served, and 4200 meals have been served.
- **Adult Day Program (ADP):** provides social, recreational and therapeutic activities designed to promote well-being though socialization and stimulation in a safe, supportive and cheerful environment. 52 clients have been served with a total of 2400 client days
- **Home at Last and Enhanced Home at Last:** Focus on clients with COPD and CHF. In Home AT Last clients are accompanied home by a PSW. Medications and groceries are picked up on the way home if required. Client is "settled in." For the enhanced program they are accompanied home and supported for 12 weeks. 108 clients have been supported with a total of 800 PSW hours.
- **Transportation:** Works in conjunction with Toronto Ride clients are escorted to medical appointments. This supports those on fixed incomes to have an affordable and safe way to get to their medical appointments. 230 people were accompanied on 9050 trips.
- **Maintenance/Grass Cutting/Snow removal:** This is a brokerage program to assist seniors with home maintenance. Available services include interior painting, washing walls and cabinets, window washing (interior and external),installation of smoke detectors and carbon monoxide units, yard work (spring and fall clean-up)and other small household repairs. 500 clients were supported through this program.
- **Foot Clinic**: On site foot clinic that provides access to foot care services for services such as nail cutting, callous removal etc. 180 clients were served with 650 visits to the clinic
- **Primary Care**: Ambulatory clinic located at Storefront Humber that is open 7 day a week; sees patients for wound care, IV therapy and post-surgical care

Patients:

- Storefront Humber serves clients in East Mississauga and West Toronto.

Other Information:

- **Mental Health Collaboration with LAMP**: Collaborated with LAMP Community Health Centre and hosted LAMP Among Friends luncheon program weekly
- **Dementia Collaboration with West Park:** working on project with West Park and Brain FX to pilot a new screener for dementia

Dorothy Ley Hospice

Name:	**The Dorothy Ley Hospice**
Type:	Palliative Care

Description:

- The Dorothy Ley Hospice (DLH) offers compassionate hospice palliative care to people living with the challenges of life-limiting illness or loss and support for their caregivers and families. Our programs meet their physical, emotional, spiritual and support needs helping them to live life to the fullest. We provide residential hospice care in our 10 bed hospice, home based palliative, ambulatory pain and symptom management clinic, case management, wellness programs, grief, bereavement and spiritual care, professional and community education and volunteer services. Over 250 active, trained volunteers provide support for both hospice operations and care for individuals and their families. The Dorothy Ley Hospice serves about 2000 people annually with services focused on the individual with a life limiting illness and their family members.

  Our services are funded through the LHIN and Ministry of Health and Long term care and through the generosity of donors and community partners. There is no charge for our services.

Services:

Residential Hospice Palliative Care:

- We provide hospice palliative care to individuals at the end of life in our 10 bed "home-like" residential hospice. We serve over 200 individuals a year in our residential hospice who come predominantly from the West Toronto, Etobicoke and East Mississauga area. Individuals are admitted to the hospice from the community and directly from hospitals. We also admit individuals from any hospital or any community in Ontario should they wish to come to the residential hospice. High quality 24/7 palliative care is delivered in the hospice by a team of skilled nurses, palliative physicians, personal support workers and volunteers.

Community Based Palliative Care:

- **In-Home Palliative Care -** The Dorothy Ley Palliative Physician team includes 12 physicians who work with the DLH case managers and volunteers to deliver in-home palliative care. The team also works with the LHIN palliative home care team. The team provides in-home palliative care to over 400 people every year and covers the geography of West Toronto, Etobicoke and East Mississauga (Lansdowne to the east, lake to the south, Steeles/401 to the north and Hurontario/Hwy 10 to the west).

  The DLH Case Managers provide care coordination, advocacy, education, information and referral and psycho-social support to palliative clients and their families. They also coordinate in-home hospice volunteers to provide respite support to caregivers and additional practical help to families.
- **Ambulatory Care Clinic for Pain and Symptom Management –** The Dorothy Ley Physicians support primary care and provide pain and symptom management consultation in an ambulatory care clinic at the hospice.
- **Pain and Symptom Management Consultants –** Two clinical nurse specialists in palliative care provide consultation and education and capacity building for community providers in LTC, primary care and in home and community care. The Pain and Symptom Management

consultants serve the city of Toronto.

- **Caregiver Support -** The Dorothy Ley Hospice provides a number of supports to caregivers including, in-home trained community volunteers for respite and support, caregiver support groups, education and training and day hospice to provide caregivers with respite and the individuals with an opportunity for socialization. Caregivers are further supported by DLH coordinators who provide information referral, education, advocacy and psycho-social supports.

Wellness, Grief, Bereavement and Spiritual Care Services:

We support the physical, emotional and spiritual needs of individuals with a life limiting illness and their families. Our programs include:

- **Integrative Wellness** - Services offered include complementary therapies such as Acupuncture, Reiki, Therapeutic Touch®, and Gentle Hand and Foot Massage, which can augment traditional pain and symptom management, and provide a restorative and relaxing experience. Pet therapy, art and music therapy are also provided in group settings.
- **Grief and Bereavement Services** – Grief and bereavement services are available to anyone anticipating a death and/or grieving the loss of someone significant, regardless of whether or not the dying/ deceased person has been connected with our Community Support or Residential Care Programs. One on one support as well as group grief and bereavement supports are available.
- **Spiritual Care Support** - Spiritual Care support is for all, whether religious or nonreligious, and it is available to individuals living with a life-limiting illness, their family and friends, and those who are bereaved. Our Spiritual Care Coordinators can also help connect individuals with faith leaders and faith communities.

Education and Outreach:

- We provide education and training about palliative care to professionals and community members. A key focus on educating individuals, families and providers on advanced care planning. We also conduct outreach in our community and work with partners to ensure individuals and their families are aware of our services and supports to ensure everyone who needs hospice palliative care has access to these services.

Patients:

- We serve individuals with all life limiting diagnoses including cancer, frail elderly and complex chronic conditions. While our residential care services are for individuals that are end of life (3 months or less) our in-home palliative care services are for those with a prognosis of 12 months or less. All of our caregiver support, case management, wellness, and spiritual care and grief and bereavement programs are available to patients at the point of diagnosis with a life limiting illness.
- We serve predominantly adults (18 years and over) however if there was a need for supporting children we would work with partners at Sick Kids to develop a support plan.
- Our catchment is West Toronto, Etobicoke and East Mississauga (Lansdowne to east, Hwy 10 west, lake to the south and Steeles/401 to the north). We are mostly in Etobicoke and West Toronto for our community programs while the in-home palliative physician services goes to East Mississauga.

Other Information:

- Dorothy Ley Hospice is accredited by CARF and has a strong commitment to quality, patient/family engagement, performance and financial management.

Appendix 2: COPD Care Pathway

What is the COPD Pathway?

Through a multi-sector collaboration, an integrated care pathway for COPD patients in West Toronto was developed. Employing a population-based approach, the integrated care pathway way was designed with a focus on meeting the community's health needs; and on improving the coordination and integration of care across the continuum of care.

The Respiratory Rehab Service at West Park provides pulmonary rehab care on an in-patient and outpatient basis. The multi-disciplinary team provides supervised exercise, education, self-management and psychological support to patients with COPD. The 26-bed inpatient unit treats the most COPD inpatient rehab cases in Ontario.

Who are the partners in the Pathway?

- Stonegate CHC (Community)
- Four Villages CHC (Community)
- Crosstown FHT (Primary Care)
- West Park Healthcare Centre (Non-Acute)
- St. Joseph Health Centre (Acute)
- Toronto Public Health
- Home and Community Care Lead
- IC/ES
- Toronto Central Local Health Integration Network (TC LHIN)
- West Toronto Primary Care Lead

What are the goals of the programs?

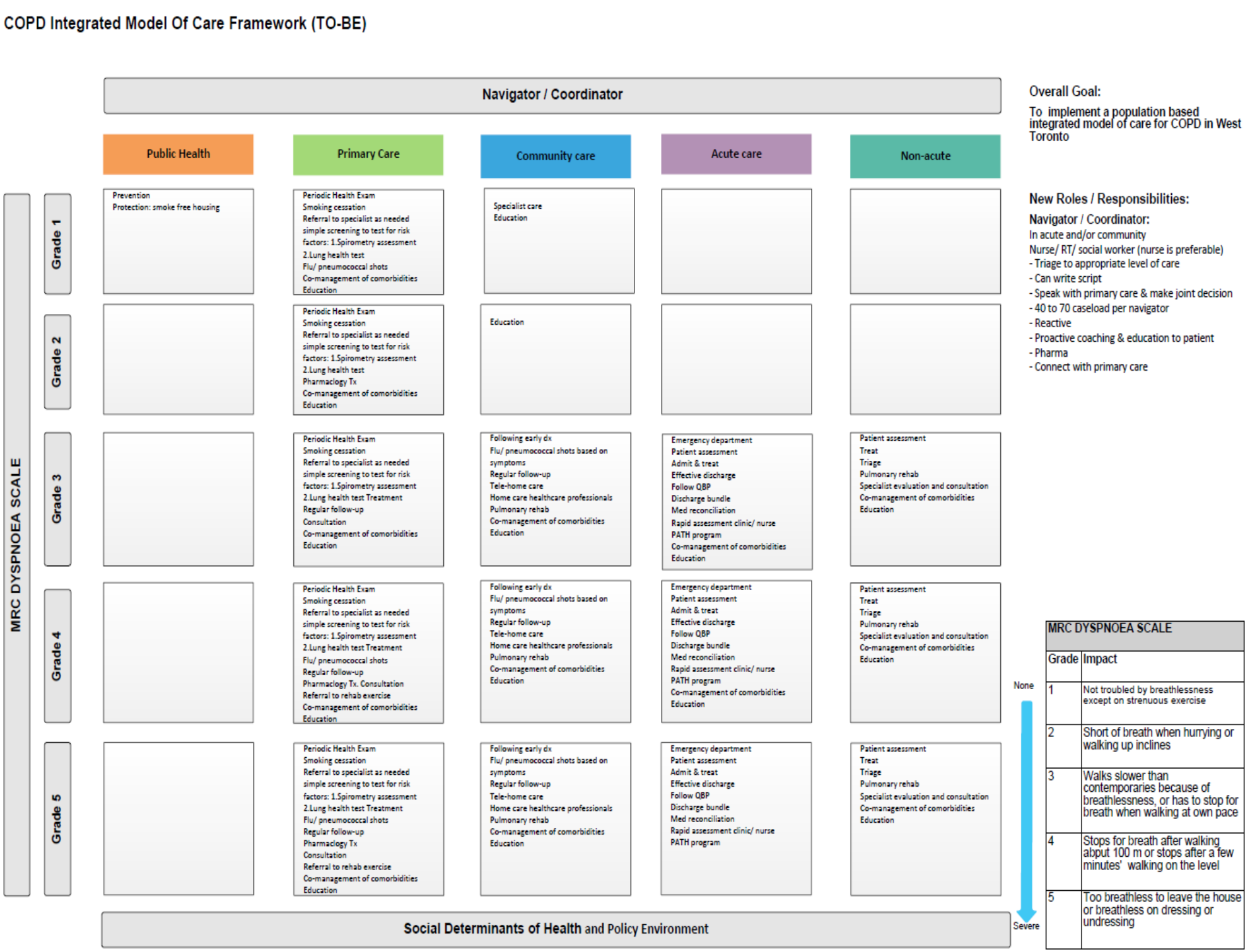
- Reduced ALC days related to COPD
- Reduced ED visits/re-visits related to COPD
- Reduced readmissions related to COPD
- Care closer to home/ community
- Improved exacerbation management
- Earlier diagnosis and intervention
- Improve patients' health and quality of life
- Optimal utilization of available resources in the local community
- Improved continuity of care
- Improved and timely referrals to specialized care
- Improved collaboration with primary care providers
- Increased awareness of COPD services and resources
- Improved case management through better self-management and overall maintenance

What have the impacts of the COPD Pathway been thus far?

- Early identification of patients at risk of readmission to acute care

- Timely access to pulmonary rehab and a shorter intake process.
- Rapid access to multidisciplinary education, coping skills training, and supervised exercise sessions
- Standardized education provided across care settings to support patents' self-management
- Enhanced target home care supports, including rapid response nursing and tele home-care are provided to support patients living at home/community.
- Since the introduction of the rapid access pulmonary rehab program at West Park, 14 patients have successfully completed the program, and 4 patients are currently in the program.

Figure 1: COPD Integrated Model of care Framework



MRC DYSPNOEA SCALE	
Grade	Impact
1	Not troubled by breathlessness except on strenuous exercise
2	Short of breath when hurrying or walking up inclines
3	Walks slower than contemporaries because of breathlessness, or has to stop for breath when walking at own pace
4	Stops for breath after walking abput 100 m or stops after a few minutes' walking on the level
5	Too breathless to leave the house or breathless on dressing or undressing

Appendix 3: West Toronto Community Network of Care

What is the West Toronto Community Connect?

West Community Connect ensures that people living in the West Sub-Region of the Toronto Central LHIN have a single point of access to community-based health services; that these services are coordinated, and that they are provided with the best combination of services and supports given their unique needs.

Community service providers have created West Community Connect to address these issues and to ensure that individuals needing care connect with those resources quickly. A key focus for the Network was developing a responsive system that will support quick and seamless transitions for patients from acute care and primary care to community-based healthcare.

What type of services did the Network provide?

Eighteen providers from community mental health providers, community addictions providers, community support services providers and hospital out-patient community care will provide a wide spectrum of services to individuals needing care in the West sub region. Services range from case management, multi-disciplinary teams and immediate access drop ins in mental health services to case management, withdrawal management and support groups in addictions to day programs, and case management, meals on wheels, transportation and care giver supports for seniors within community support services.

In the 2017/2018 fiscal year, 28 community health service providers including mental health, addictions, and community support services provided services to over 18,000 in this sub region. Services to each of these sectors happens through a variety of access points; services for individuals with multiple service needs are often uncoordinated and the navigation of complex systems are the responsibility of the individual or the referring organization rather than the system being accessed.

What are the benefits of the Network of Care?

Health Service providers gain simplified and timely access to mental health services, addictions services and community support services in West Toronto through a local access “hub” that virtually connects all existing community-based services within the Network. Transparency in declaring, managing, and sharing capacity across and between programs and health service providers maximizes opportunities for access. Geographic alignment of providers ensures coverage of service types and maximum efficiency in care delivery. The use of technology is also in the process of being integrated to enable point-in-time navigation and referral by all partners.

A Steering Committee has been established with representation from all sectors and stakeholders to govern and ensure the goals of the Network are met and Working Groups assisted with the designing of the system to ensure accountability and transparency in sharing resources. Memorandums of understanding from each partner ensure accountability to the goals of the Network and transparency in capacity management and resource sharing.

Appendix 4: West Toronto Primary Care Strategy

What is the West Toronto Primary Care Strategy?

Primary Care is an essential base for the needs of the population of any identified geography. Since June 2016, TC LHIN pushed out an aggressive rethink of Primary Care. Extensive interviewing took place with PCPs and patients before actual work started.

TC-LHIN was divided into 5 Sub-Regions, each Sub-Region with a PCCL and a small staff. A Hospital Resource Partner was designated (SJHC). The West Sub-Region Primary Care Strategy Team started its work in late 2016. Its work was to engage providers, build connections with the various delivery components of the West health care network, innovate and collaborate with various partners, and to roll-out regional LHIN-wide priorities but with a local perspective. Being a "driver for change" was part of the mandate.

What work has been completed and is ready to be leveraged?

- Establishment of a Primary Care and Community Committee which includes representatives of all physician remuneration models, providers all local CHC's and FHTs, SJHC Clinical EVP, Chief of Family Medicine SJHC, Head of Home and Community Care West Toronto, and representatives of Mental Health and Community Services. The Committee meets regularly and is a forum for discussion of Primary care needs.
- Engagement activities for PCPs establishing relationships with about 50 % of the providers. Many activities (including continuing Professional development to improve care and review evidence-based recommendations for care).
- Groundwork on establishing a Patient Primary Care Focus Group.
- Establishment of an Inter-professional Team providing Mental Health, Addictions and Chronic Disease Management for PCPs and patients that are not members of an FHT or a CHC in the high-needs area of Mt. Dennis/Rockcliffe-Smythe. Establishment of an Advisory Group of multiple community partners.
- Establishment of a Mental Health Worker program, based at LAMP CHC providing care to PCPs and patients not associated with an FHT or a CHC.
- Roll out of the ONEID Bundle (OneMail, eConsult and ConnectingOntario) and other digital solutions in the West Sub-Region.
- Establishment and Expansion of the SCOPE program to over 80 West Toronto Primary Care physicians through SJHC, improving access to Specialty Care, Diagnostic Imaging, Urgent Home and Community Care and Systems Navigation.
- West Toronto Health Link work involved with engaging hospital and community partners in Coordinated Care Planning for Complex Patients. Engagement has started with PCPs in the community.
- Work developing regionally and then starting to spread locally an electronic CCP platform.
- Supportive work with Neighbourhood Care Teams in South Parkdale and Roncesvalles.
- Participation in MLAA projects with SJHC, Home and Community Care, WPHC.
- Movement from TC LHIN to the community of a West Toronto Home Based Primary Care Team.
- Needs Assessment to be completed with Primary care Providers in West Toronto. (this fiscal)
- Public engagement event planned for Navigating Mental Health and Addiction Service in West Toronto this fiscal year. (such an event already held with physicians)
- West Toronto Primary care newsletter and communications sent out on a regular basis to PCPs.

What other projects has the West Toronto Primary Care team been involved in?

- West Toronto Integrated COPD program (almost ready to go) (participation in Steering Committee)
- West Toronto Integrated Primary Care Seniors Initiative. (spearheaded by the team) In final planning stages.
- Integrative Mental Health (we are currently pulling together the partners that need to be involved for success)

LHIN-wide initiatives include:

- Expanding MyChart (now available to patients at both SJHC and WPHC)
- Enforcing standards for Hospital Discharge Summaries
- PODS (Patient Oriented Discharge Summaries)
- Encouragement of uptake of HRM
- Expansion of Health Care Connect
- Development of Specialist and Community Services Directories
- Primary Care/ Public Health WG
- Telemedicine Impact Plus (for vulnerable, complex patients)
- Managed Entry to FHOs
- SPIN (access to inter-professional teams)

In addition, The Primary Care Regional Council (TC LHIN) has spent a great deal of time on developing a maturity model for Primary Care, including gaps that need to be filled (presented recently at the International Conference on Integrated Care in San Sebastian to enthusiastic reception). It is an enhancement of the Patient Medical Home model proposed by The College of Family Physicians of Canada.

Acronyms Used:

- PCP- Primary Care Provider
- SJHC-St. Joseph's Health Centre
- WPHC-West Park Health Centre
- TC LHIN-Toronto Central Local Health Integration Network
- HCC- Home and Community Care
- SR- Sub-Region

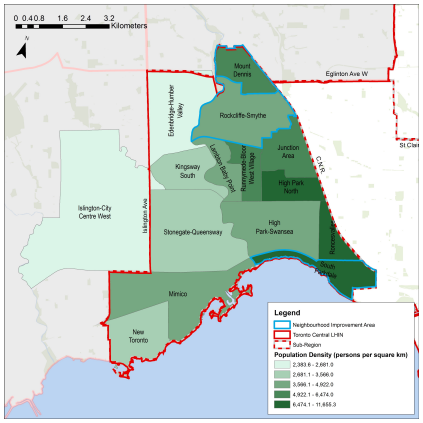
Appendix 5: Geographic Region for West Toronto Ontario Health Team

Ontario
Toronto Central Local Health Integration Network

Executive Mini Profile

Appendix 6

West Toronto



****DRAFT VERSION FOR CONSULTATION**

Demographic Information

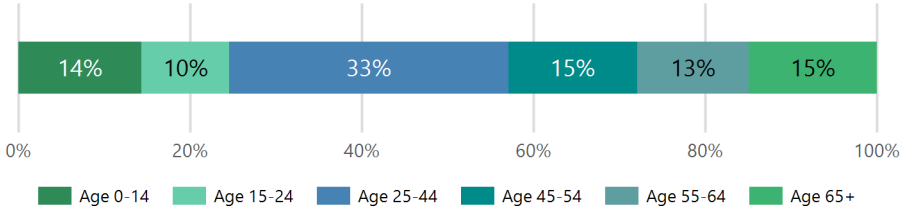
Populations

Total Population (Year 2016)
245,490

Male
118,345(48%)

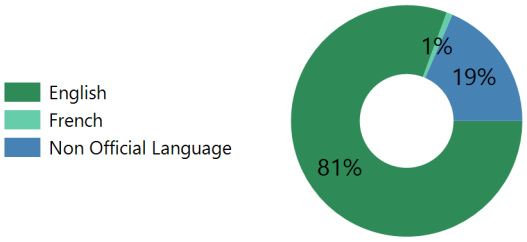
Female
127,210 (52%)

Chart 1. Age Group Percentage Chart



Language

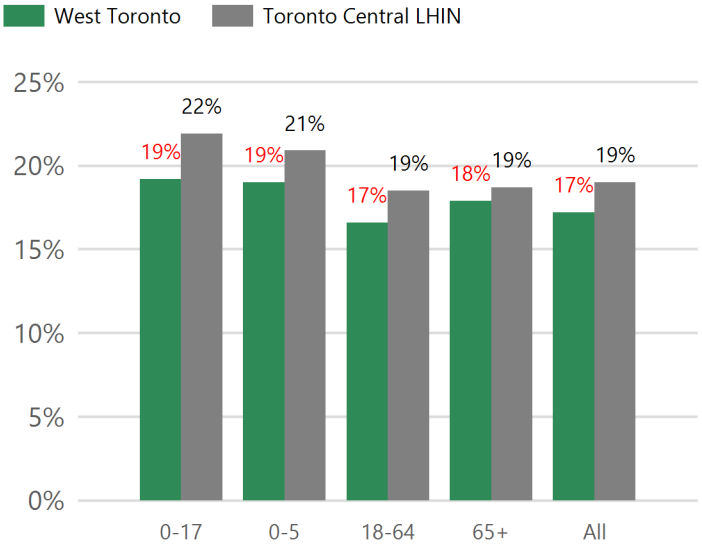
Chart 2. Percentage of population for whom most spoken language at home is one of the official languages



The top 3 most spoken languages other than English & French are:
Spanish, **Portuguese**, and **Polish**

Low Income Measure (After Tax) by Age Groups

Chart 3. Percentage of Population (by age groups) below Low Income Measure (After Tax)

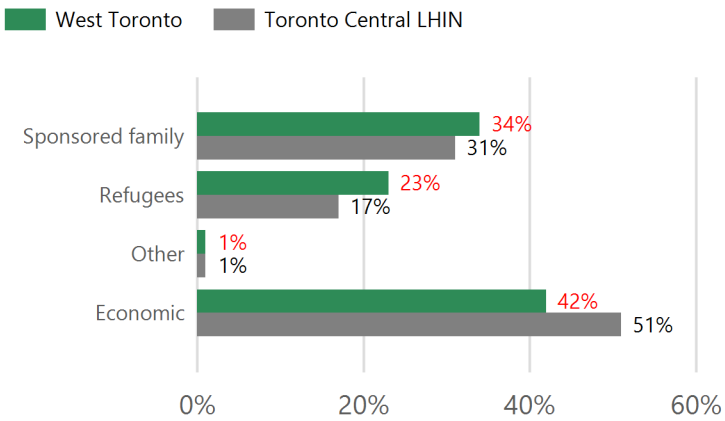


Immigration

Immigrants: 37% (36% in Toronto Central LHIN)

Recent Immigrants: 4% (5% in Toronto Central LHIN)

Chart 4. Percentage of Immigrants (landed after 1980 only) by Admission Category



Health Profile

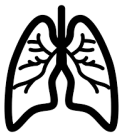
Age-Standardized Rate: To determine whether a Sub-Region has a higher occurrence against the measure given the number of people living in the Sub-Region and their age distribution, the age-standardized rate and it's confidence intervals are calculated to provide a standard measure to determine if the occurrence is statistically **higher (H), lower (L) or similar (NS)** than the LHIN overall.

****Non-Standardized:** It provides direct comparision than significant comparison of rates, so **higher (H), lower (L) or similar (NS)** may not indicate statistically significant difference.

Adult Health and Disease (rates per 100 population)

Diabetes
West Toronto compared to Toronto Central LHIN: **Similar**
Number of People (Ages 20+, FY 16/17): **21,637**
West Toronto's Age-Standardized rate: **9.3**
Toronto Central LHIN's Age-standardized rate: **9.2**

High Blood Pressure (HBP)
West Toronto compared to Toronto Central LHIN: **High**
Number of People (Ages 20+, FY 16/17): **47,016**
West Toronto's Age-Standardized rate: **19.9**
Toronto Central LHIN's Age-standardized rate: **19.3**



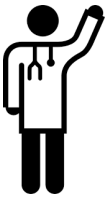
Chronic Obstructive Pulmonary Disease (COPD)
West Toronto compared to Toronto Central LHIN: **Similar**
Number of People (Ages 35+, FY 16/17): **13,607**
West Toronto's Age-Standardized rate: **9.2**
Toronto Central LHIN's Age-standardized rate: **9.1**

Mental Health and Addiction-related Visits
West Toronto compared to Toronto Central LHIN: **High**
Number of People (Ages 20+, FY 16/17): **20,409**
West Toronto's Age-Standardized rate: **10.0**
Toronto Central LHIN's Age-standardized rate: **9.6**

4+ Chronic Conditions
West Toronto compared to Toronto Central LHIN: **Similar**
Number of People (Ages 0+, FY 15/16-16/17): **4,894**
West Toronto's Age-Standardized rate: **8.3**
Toronto Central LHIN's Age-standardized rate: **8.4**

Dementia
% of Toronto Central LHIN cases that are West Toronto's: **10.9%**
Number of Cases in West Toronto (Ages 40+, FY 15/16): **2,695**
Number of Cases in Toronto Central LHIN (Ages 40+, FY 15/16): **12,132**

Primary Care



Non-Enrolled**
West Toronto compared to Toronto Central LHIN: **High**
West Toronto's % of Non-Enrolled (Ages 0+, FY 14/15-15/16): **30.8%**
Toronto Central LHIN's % of Non-Enrolled (Ages 0+, FY 14/15-15/16): **30.6%**

Low Continuity**
West Toronto compared to Toronto Central LHIN: **Low**
West Toronto's % Low Continuity (Ages 0+, FY 14/15-15/16): **16.3%**
Toronto Central LHIN's % Low Continuity (Ages 0+, FY 14/15-15/16): **16.7%**

Emergency Department (ED) Care (rates per 1,000 population)

All Unscheduled Emergency Department (ED) Visits
West Toronto compared to Toronto Central LHIN: **High**
Number of ED Visits (Ages 0+, FY 15/16-16/17): **195,531**
West Toronto's Age-Standardized rate: **380.3**
Toronto Central LHIN's Age-standardized rate: **322.1**

High Urgency ED Visits
West Toronto compared to Toronto Central LHIN: **High**
Number of ED Visits (Ages 0+, FY 15/16-16/17): **137,633**
West Toronto's Age-Standardized rate: **261.6**
Toronto Central LHIN's Age-standardized rate: **230.4**

Low Urgency ED Visits
West Toronto compared to Toronto Central LHIN: **High**
Number of ED Visits (Ages 0+, Year 15/16-16/17): **57,591**
West Toronto's Age-Standardized rate: **118.1**
Toronto Central LHIN's Age-standardized rate: **91.1**

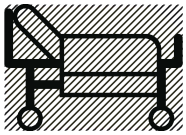
Hospital Admission

All Unscheduled Acute Hospital Admission (rates per 1,000 population)
West Toronto compared to Toronto Central LHIN: **High**
Number of Admissions (Ages 0+, FY 15/16-16/17): **38,579**
West Toronto's Age-Standardized rate: **70.2**
Toronto Central LHIN's Age-standardized rate: **66.2**

30-day Readmissions to any Hospital (%)**
West Toronto compared to Toronto Central LHIN: **High**
Number of 30-day Readmissions (FY 17/18): **541**
West Toronto's 30-day Readmission rate: **17.1%**
Toronto Central LHIN's 30-day Readmission rate: **16.9%**

Alternate Level of Care

Alternate Level of Care (ALC)**
West Toronto compared to Toronto Central LHIN: **High**
West Toronto's % of Hospital Days that are ALC (Ages 0+, FY 15/16-16/17): **17.7%**
Toronto Central LHIN's % of Hospital Days that are ALC (Ages 0+, FY 15/16-16/17): **16.1%**



Home Care Utilization (rates per 1,000 population)

Active Patient Referrals Crude Rate**
West Toronto compared to Toronto Central LHIN: **Low**
West Toronto's Active Patient Referrals Crude Rate (FY 17/18): **38.0**
Toronto Central LHIN's Active Patient Referrals Crude Rate (FY 17/18): **40.4**

Home Care Profile: *Looking at FY17/18 Clients*

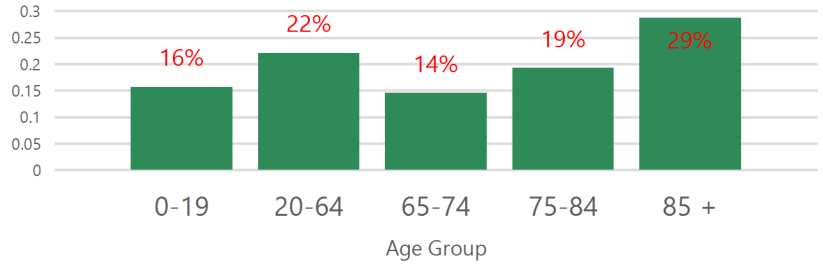
FY17/18 Home Care Client Population

9,885
Total Clients (FY 17/18)

Male 45%

Female 55%

Chart 5. Proportion of FY17/18 Home Care Clients by Age Group



Rate of Services by Type-Hours per 1,000 population (FY17/18)

	PSW	Respite	Nursing_Shift
West Toronto	2,805.5	60.4	154
Toronto Central LHIN	2,564.8	53.8	123.9
Comparison	High	High	High

Rate of Services by Type-Visits per 1,000 population (FY17/18)

	Nursing_Visits	OT	PT	SW	ST	Nutrition
West Toronto	564.8	40.1	55.8	2.6	20.7	2.4
Toronto Central LHIN	476.7	41.8	61.7	1.9	23.3	2.3
Comparison	High	Low	Low	Low	Low	High

Caregiver Distress - Clients with interRAI-HC

48.3%
Caregivers Reporting Distress

Diseases - Clients with interRAI-HC

25.9%
Clients with Dementia/Alzheimer's

25.9%
Clients with Diabetes

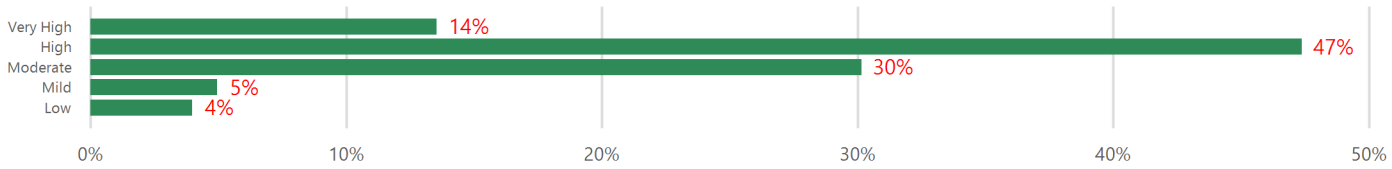
8.8%
Clients with Chronic Obstructive Pulmonary Disease (COPD)

Living Alone - Clients with interRAI-HC

40.5%
Clients who lived alone

MAPLe Score- Clients with interRAI-HC

Chart 6. Proportion of unique clients for long stay HC referrals by MAPLe Score



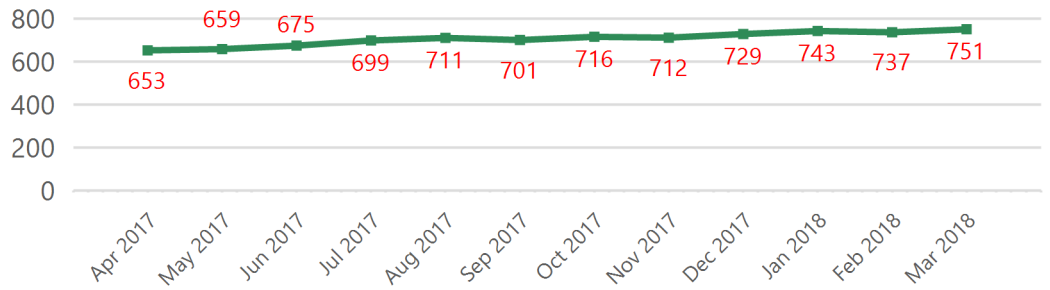
Long Term Care (LTC) Profile: *Looking at FY17/18 Clients*

FY17/18 LTC Clients

1,203 **Active LTCH Placement applications at any point during FY17/18**

559 **New LTC Placement applications initiated in FY17/18**

Chart 7. Number of Active LTC Referrals at the End of each Month



Appendix 7: Digital Solutions Utilized

Name	Description
ONE MAIL	ONE Mail Direct is a secure email service designed specifically for small organizations and for individual regulated health care professionals in Ontario. This encrypted service, hosted in our highly-secure infrastructure, allows users to securely and confidentially exchange patient health information (PHI) or personal information (PI) with other ONE Mail users.
E-Consult	Connects requesting providers to specialists, providing the opportunity to inform clinical decision making without sending the patient to see the specialist in person. Through a private and secure web portal, requesting providers can ask a specialist a clinical question about their patient and receive advice quickly and securely.
ConnectingOntario	The ConnectingOntario ClinicalViewer is a secure, web-based portal that provides real-time access to digital health records including dispensed medications, laboratory results, hospital visits, Local Health Integration Networks' (LHIN) Home and Community Care Services, mental health care information, and diagnostic imaging reports and images.
RM&R	Resource matching and referral (RM&R) is an electronic information and referral system that matches health care clients to the earliest available services that best meets their needs. This solution queries a directory of facilities, programs and services that meet the client's needs within an identified level of care. Once an appropriate facility and service have been identified, an electronic referral, or eReferral, directs the health care client from a source caregiver to a target caregiver (health professional or institution), recommending the required type and level of care. For example, users could locate a suitable long-term care facility for a health care client who is currently waiting to be transferred from a hospital.
Caredove	A referral management Software-as-a-Service platform designed to transform how access to home care and community services works for everyone involved. Caredove is for health leaders committed to applying proven quality improvement principles to any health-care transition.
eCCP	A web-based application allowing members of the circle of care within different health service providers to collaborate securely and efficiently by creating, updating, sharing, and viewing a client's coordinated care plan electronically.
HRM	An eHealth solution that enables clinicians using an OntarioMD-certified EMR to securely receive patient reports electronically from participating hospitals and specialty clinics.
MyChart	An online website where patients can create and manage their own personal health information based on clinical and personal information.
OLIS	The Ontario Laboratories Information System (OLIS) is an information repository that gives authorized health care providers access to lab test orders and results from hospitals, community labs and public health labs. As patients move between hospitals, family physicians, home care and long-term care settings, OLIS makes viewing patients' current and past test results easier and enables treatment decisions to be made at the point-of-care.
CHRIS	CHRIS (Client Health and Related Information System) supports the delivery of care at home and in the community for 670,000 patients in Ontario. Patients get the right care at the right time and place because of features in CHRIS. CHRIS has a

	secure online portal called Health Partner Gateway* (HPG*). Approved providers can access patient records, including clinical assessments and documents, and share up-to-the-minute patient information on HPG. Providers can also send, receive, and accept patient referrals and service orders in real-time. HPG breaks down silos by connecting an ever-expanding list of providers.
IAR	The Integrated Assessment Record (IAR) tool provides a central repository for clinical assessment data collected from multiple community care sectors. It allows authorized Health Service Providers (HSPs) within the circle of care to upload and view a client's assessment information in a secure and timely manner. The IAR enables collaborative care planning as well as enhanced communication between providers, for the ultimate goal of promoting high quality care for clients in the community.

Appendix 8: Neighbourhood Care Integration in West Toronto

What is the Neighbourhood Care Vision?

Integrated model of care that is accountable to meeting the needs of people living within a high-density urban neighbourhood. People will experience one system that provides simple access to service, navigation / coordination if unable to self-navigate and streamlined communication of health care providers

Early Implementation

- 10 City of Toronto neighbourhoods identified as initial intervention locations
    - Identified need based on utilization data
    - Identified opportunity for local service integration
    - Distribution of neighbourhoods across regions
    - Clear presence from core group of service providers
    - Primary care presence (ideally interprofessional model)
- **2 West Toronto neighbourhoods selected:** Roncesvalles and South Parkdale
    - At least one health service provider (HSP) and one home care service provider organization (SPO) identified as primary providers of care in initial neighbourhoods
        - Current presence and relationships in neighbourhood
        - Aligned with geographic alignment
        - **West Toronto Partners:** LOFT, West Neighbourhood House, Paramed and SRT
    - Providers tasked with co-creating a Neighbourhood Care Team model

Realignment of Community Coordinators and Service Providers

Support Our Health System Commitments to:

- Delivering Coordinated Community Care and Primary Care close to Home
- Integrated Health Care

Geographic Realignment initiatives will:

- Consolidate agency PSW and Nursing volumes within fewer city neighbourhoods and sub-regions to support local delivery models and coordinated care planning
- Align Care Coordinator Caseloads to city neighbourhoods and sub-regions
- Support Neighbourhood Care Team delivery models through the assignment of a single service provider in 10 pilot neighbourhoods throughout the TC-LHIN.

Re-alignment in Home & Community Care

Key Principles

- Streamline access to Home and Community Care for our clients and health service providers
- Improve client experience and equity, reduce wait times, and increase capacity to support integrated service delivery
- Build the level of impact that Care Coordinators can have on the health and wellbeing of the citizens of Toronto
- In these changes, we have held to two key principles to support the objectives:
    - Minimize the adverse impact on our clients
    - Be coordinated with existing realignment, integration, and neighbourhood care team strategies and projects

Update: Program launched at the end of March 2019; Phase 2 planning underway