Ontario Health Team: Full Application

Introduction

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

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

Based on an evaluation of the intake and assessment documentation submitted to date, your team has been invited to submit a Full Application, which will build on information your team has provided regarding its collective ability to meet the readiness criteria, as set out in *'Ontario Health Teams: Guidance for Health Care Providers and Organizations'* (Guidance Document). It is designed to provide a complete and comprehensive understanding of your team and its capabilities, including plans for how you propose to work toward implementation as a collective. This application also requires that your team demonstrate plans for encouraging comprehensive patient and community engagement as critical partners in population health, in alignment with the *Patient Declaration of Values for Ontario*.

Please note that the application has been revised to reflect lessons learned from the previous intake and assessment process. It consists of five sections:

1. About your population
2. About your team
3. Leveraging lessons learned from COVID-19
4. Plans for transforming care
5. Implementation planning
6. Membership approval

OHT Implementation & COVID-19

The Full Application asks teams to speak to capacity and care planning in the context of the COVID-19 pandemic. The Ministry of Health (the Ministry) is aware that implementation planning is particularly challenging in light of the uncertain COVID-19 trajectory. It is our intention to have this Full Application assist with COVID planning, while at the same time move forward the OHT model. Work on the Full Application should not be done at the expense of local COVID preparedness. If the deadline cannot be met, please contact your Ministry representative to discuss other options for submission.

<u>Information to Support the Application Completion</u>

At maturity, Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a defined population of Ontario residents and will be accountable for the health outcomes and health care costs of that population. This is the foundation of a population health model, as such (at maturity) Ontario Health Teams need be sufficiently sized to deliver the full continuum of care, enable effective performance measurement, and realize cost containment.

Identifying the population for which an Ontario Health Team is responsible requires residents to be attributed to groups of care providers. The methodology for attributing residents to these

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

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

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

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

Participation in Central Program Evaluation

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

Submission and Approval Timelines

Please submit your completed Full Application to the ministry by September 18th, 2020. If the team is unable to meet this timeline due to capacity concerns associated with COVID Wave 2/Flu preparedness and response, future submission dates will be announced in the fall. Please note, teams that submit their Full Application on or before September 18th, 2020 will receive results of the Full Application review by October 19th, 2020 (pending any unanticipated delays associated with COVID-19 Wave 2).

Successful candidates will be considered "Approved" Ontario Health Teams. Unsuccessful candidates will be provided a summary of the evaluation and review process that outlines the rationale for why they were not selected and the components that require additional attention. Teams will work with the Ministry to determine the path to reach the Approved status.

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

Additional Notes

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

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

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Jan Walker
	Title: VP Strategy, Innovation & CIO
	Organization: West Park Healthcare Centre
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Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Gillian Bone
	Title: Deputy CEO
	Organization: The Four Villages Community Health Centre
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1. About Your Population

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

1.1. Who will you be accountable for at maturity?

Confirming that teams align with their respective attributed patient population is a critical component of the Ontario Health Team model. It ensures teams will care for a sufficiently-sized population to achieve economies of scale and therefore benefit from financial rewards associated with cost containment through greater integration and efficiencies across providers. It is also necessary for defining the specific population of patients a team is to be held clinically and fiscally accountable for at maturity, without which it would not be possible for teams to pursue population-based health care and expense monitoring and planning.

Based on the population health data provided to you, please describe how you intend to work toward caring for this population at maturity:

Maximum word count: 500

At maturity, our goal is to provide vertically integrated care to our attributed population (231,244) taking a population health and equity approach as a foundation to achieve better health outcomes and to meet the Quadruple Aim. We will stratify our populations based on risk factors related to their health outcomes to enable planning, co-design and implementation of services that meet the diverse needs of all patients, families and caregivers in culturally-appropriate ways. In collaboration with existing providers and patients, families and caregivers, we will implement innovative care models by integrating wellness, resilience and prevention as key focus of care in all settings and ensure that the total population of ~527,000 in West Toronto is cared for.

As part of our planning, we are considering the following:
1) Attributed population,
2) Proposed planning areas and attribution of neighbouring OHTs,
3) Learnings from our collaborative partners to understand referral patterns and ensure provision of a full continuum of care to meet the care needs of our community,
4) Known mechanisms on how neighbourhoods and patients access services.

As we broaden our knowledge of those seeking care in primary care, specialist and hospital settings in West Toronto through the attribution data, our goal is to shift service delivery models and utilization patterns so that more people have access to services closer to home in West Toronto, including vulnerable populations (e.g. non-OHIP patients, individuals who are precariously housed, newcomers etc.).

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

The West Toronto region spans Lawrence Ave. West to the North, Ossington Ave. to the East, Lake Ontario to the South, and Etobicoke Creek to the West. Our partners informed this description of where we provide care, where our patients, caregivers and families seek care and where they reside. We also intend to provide care for all of Etobicoke, which historically has been sub-divided into different regions (across four LHINs) from a planning, service delivery and funding perspective and will include attributed populations from neighbouring OHTs.

We have multiple partners that provide services for the populations highlighted in our catchment region described above. We have expanded our partnerships focusing on targeted outreach to other providers and community organizations to ensure the local provision across the full continuum of care to meet the needs of our community. In addition, we will engage other collaborative groups of providers and organizations to leverage their service delivery models to meet these needs in a more integrated and fulsome way for client access and for provider efficiency. The knowledge of local community needs from our partners will help in this planning, especially when considering location of service delivery in the community and home.

We are leveraging our knowledge of funding envelopes and other data sources such as Health Quality Ontario, and patient experience data, as well as data from the Ontario Community Health Profiles Partnership, and information from our partners. These, in combination with the data package from the Ministry, will enable us to evolve and better target our programs to specific segments of the attributed population.

1.2. Who will you focus on in Year 1?

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

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

If this Year 1 population differs from previously submitted documentation, please provide a brief explanation (for example, many teams have seen changes to their priority populations as a result of COVID-19).

Maximum word count: 500

Our Year 1 priority population, identified in the Self-Assessment, continues to be our focus. This includes patients with severe COPD post-acute exacerbation, frail seniors with increasing risk and adults 18 years and over with mental health and addictions (MHA) needs who are using ED frequently.

In 2016, 5.2% of persons living in West Toronto (N= 250,371) had COPD. From October 2018 to September 2019, St. Joseph's Hospital saw 525 ED visits with a 60% admission rate, and 179 repeat ED visits within 30 days. COPD ranked #76 health condition for the attributed population within our network.

Based on the attributed population of 2017/18, 16.6% are seniors aged 65 and over and contribute to ED visits and admissions. St. Joseph's saw 19,466 ED visits with a 30% admission rate, and 4,456 repeat ED visits within 30 days for patients 65+ years. (October 2018 to September 2019). Over the last year, we have been developing a Framework for Frail Seniors, focusing on the categories of Rising Risk and High Risk.

West Toronto has higher rates of repeat ED visits (37.9%) in comparison to the provincial rate (24.8%) in 2017/18 Q4. In addition, frequent ED visit rate (4+ visits / year) for MHA is 14.5% compared to the provincial rate of 9.5%. (OHT Data Package, 2020). St. Joseph's, on average, sees over 500 adult and almost 40 child and youth MHA related ED visits monthly with 40% child and youth visits resulting in admissions. St. Joseph's saw 6,699 ED visits with 20% admission rate, and 2,024 repeat ED visits within 30 days (October 2018 to September 2019). This is reinforced by the attributed population data indicating that Neurotic/Anxiety/Obsessive Compulsive Disorder are ranked 7th within our network compared to 11th for the province. There is also a large number of patients seeking services from the Centre for Addiction and Mental Health: a significant number from the Parkdale neighbourhood living in supportive housing and boarding homes supported by community providers. Providers have noted the increased number of patients presenting with MHA needs, such as depression during the pandemic.

West Toronto is a unique area in terms of people accessing and using services in Toronto and availability of services in our region. Social determinants of health, namely economic stability and built neighbourhood related to changes in the housing market, play an important role in the health and wellbeing of our population.

Avoidable ED visits and admissions constitute significant costs to the health care system and negatively influence patient/client and caregiver experience in West Toronto. The team is working to identify opportunities to improve care, ensure better connections with primary care, and expand partnerships to address social determinants of health as well as access and accessibility of services for the population. Our intention is to make services easily accessible in order to encourage the West Toronto

population to seek care closer to home, and to shift the way services are provided to ensure that we are meeting the health and social care needs in our community.

1.3. Are there specific equity considerations within your population?

Certain population groups (e.g., Indigenous peoples, Franco-Ontarians, newcomers, low income, racialized communities, other marginalized or vulnerable populations, etc.) may experience health inequities due to socio-demographic factors. This has become particularly apparent in the context of the COVID-19 pandemic response and proactive planning for ongoing population health supports in the coming weeks and months. Please describe whether there are any population sub-groups within your Year 1 and attributed populations whose relative health status would warrant specific focus.

Maximum word count: 1000
Where known, provide information (e.g., demographics, health status) about the following populations within your Year 1 and attributed populations. Note that this information is not provided in your data support package. LHIN Sub-Region data is an acceptable proxy.[3] Other information sources may also be used if cited.

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

The population of West Toronto is diverse, with immigrants making up 37% of the population, and recent immigrants accounting for 4%. Visible minorities make up 33.6% of the population with the largest visible minorities reported as Black, South Asian and Latin American. The top three languages spoken other than French and English are Spanish, Portuguese, and Polish, with 4.2% of the population having no knowledge of English or French. The percentage of the population living below the low-income measure is 17%, ranging from 5.8% - 34.1% at the neighbourhood level. There are two homeless shelters in the Mimico and Junction areas. Data provided by CHCs indicate that there are uninsured patients in our region accessing services, resulting from newcomer status or homelessness/precariously housing. There is a high number of the population with low education and unemployment rate accounts for 7.1%. Based on patient choice, our attributed population accessing services across Toronto region and West Toronto reflects this typical urban experience.

West Toronto residents, and those seeking care in West Toronto and in neighbouring OHTs within our year 1 population focus, includes population groups who experience health inequities due to socio-economic factors. Recent data from the City of Toronto has further highlighted these inequities in the context of COVID-19. The communities with mental health and addictions needs in West Toronto region are highly marginalized with low income, chronic conditions and housing issues. During COVID-19, we have seen an accentuation of food insecurity and housing issues among this

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

population. The theme of food security and social isolation more broadly affect isolated seniors, people living alone with chronic conditions and low-income individuals and families.

City of Toronto data show that COVID-19 cases and hospitalizations were more commonly reported among those living in areas of Toronto with higher proportions of low-income earners and recent immigrants. Certain racialized groups, as mentioned above, were found to be over-represented in areas with higher COVID-19 case rates.

Geographic based data highlights that the north and west neighbourhoods of West Toronto report higher rates of COVID-19 compared to other neighbourhoods, and that this coincides with racialized communities noted above. We will continue to work closely with our City of Toronto partners including community agencies and organizations that represent and serve communities that are experiencing higher impact of COVID-19 to identify areas of potential collaboration to address these disparities. This includes continuing to recommend areas for enhanced and mobile testing, including pop-up centres and targeted health promotion messages with Toronto Public Health and Ontario Health to help reduce virus spread and prevent further transmission.

While the shift to virtual care has expanded access for some patients, the pandemic has exposed gaps with unequal access to digital health, which further perpetuates disparities in health.

"My barrier was that at that time you were offering virtual programming. I do not have access to internet at home. Without internet I had no way of participating." Patient in West Toronto.

Of particular concern is the impact on all vulnerable populations, including Indigenous and Francophone communities for language and culturally specific messages. Our goal is to work with our members across sectors to increase access and remove barriers to virtual programming, and facilitate access to digital literacy training for these populations.

We have identified the importance of considering the needs of people with disabilities living in West Toronto, many of whom are supported by community based regional service providers that work across multiple OHTs in the GTA. The Canadian Survey of Disability (2017) found people with disabilities across the lifespan experience health disparities compared to adults without a disability. Data show that adults with a disability were more likely to be affected by:

- Health and health risk behaviors i.e. have cardiovascular disease; be obese; be a current smoker; have no leisure-time physical activity
- Lack of health care access i.e. adults with a disability were less likely to have a current mammogram; be receiving needed medical care
- Lack of access to facilities, e.g. exam tables that are adjustable
- Lack of access to mental health supports, where health care professionals see the disability and ignore other issues. Treat the physical limitations as the primary issue.

Toronto has the largest and most diverse urban Indigenous population in Ontario (Environics Institute, 2010). While, there is little local data on Indigenous health, national and First Nations databases indicate that Indigenous people fare worse than the non-Indigenous population on many health indicators (Gionet & Roshanasfshar, 2013; Olding et al., 2014). Indigenous people living in Toronto face challenges across the social determinants of health, and barriers in accessing health services, which have been further exacerbated during the pandemic. Indigenous people experience higher rates of poverty, unemployment, homelessness, involvement with child welfare, food insecurity and challenges within the education system – all contributing to poor health outcomes (McCaskill et al., 2011; NCCAB, 2013; Olding et al., 2014; Steward et al., 2013). Toronto's First Indigenous Health Strategy (2016) highlights that reducing health inequities experienced by Toronto's Indigenous community requires a coordinated and wholistic approach – one that harmonizes traditional and mainstream health programs and services.

As part of our work to address anti-Black racism and improve health outcomes for Black communities in West Toronto we have identified areas of work to address systemic racism, inequities in access and outcomes and increasing diversity in leadership and governance. The group will be focusing on three priorities:

- Education: sharing resources to help all providers understand the magnitude of the problem and to gain a common understanding of the broader context of systemic racism and the specific context in West Toronto, as well as to understand our role as allies.
- Data: Expand the collection of race-based socio-economic data to understand whom we serve and where there are poorer health outcomes. This could start to inform how we address the issue of health inequities.
- Disrupting the cycle of systemic racism through governance and accountability by identifying actionable steps to implement anti-racist practices.

2. About Your Team

In this section, you are asked to describe the composition of your team and what services you are able to provide.

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

At maturity, Ontario Health Teams will be expected to provide the full continuum of care to their defined patient populations. As such, teams are expected to have a breadth and variety of partnerships to ensure integration and care coordination across a range of sectors. A requirement for approval therefore includes **the formation of partnerships across primary care** (including inter-professional primary care and physicians), **both home and community care, and secondary care** (e.g. acute inpatient, ambulatory medical, and surgical services). In addition, to ensure continuity and knowledge exchange, teams should indicate whether they have built or are starting to build working relationships with their Local Health Integration Networks (LHINs) to support capacity-building and the transition of critical home and community care services.

Given the important work ahead in the Fall in preparation for cold and flu season and the potential for wave 2 of COVID-19, teams should look at efforts to engage with public

health and congregate care settings including long-term care, and other providers that will allow teams to leverage partnerships that support regional responses and deliver the entire continuum of care for their patient populations.

As Ontario Health Teams will be held clinically and fiscally responsible for discrete patient populations, it is also required that overlap in partnerships between teams be limited. Wherever possible, physicians and health care organizations **should only be members of one Ontario Health Team**. Exceptions are expected for health care providers who practice in multiple regions and home and community care providers, specifically, home care service provider organizations and community support service agencies, provincial organizations with local delivery arms, and provincial and regional centers.

Keeping the above partnership stipulations in mind, **please complete sections 2.1.1 and 2.1.2 in the Full Application supplementary template.**

2.2. Confirming Partnership Requirements

If members of your team have signed on or otherwise made a commitment to work with other teams, **please identify the partners by completing section 2.2. in the Full Application supplementary template.**

Team Member	**Other Affiliated Team(s)** *List the other teams that the member has signed on to or agreed to work with*	**Reason for affiliation** *Provide a rationale for why the member chose to affiliate itself with multiple teams (i.e. meets exceptions identified previously e.g. specialized service provided such as mental health and additions services)*

2.3. How can your team leverage previous experiences collaborating to deliver integrated care?

Please describe how the members of your team have previously worked together to advance integrated care, shared accountability, value-based health care, or population health, including through a collaborative COVID-19 pandemic response if applicable (e.g., development of new and shared clinical pathways, resource and information sharing, joint procurement; targeted initiatives to improve health on a population-level scale or reducing health disparities, or participation in Health Links, Bundled Care, Rural Health Hubs).

Describe how existing partnerships and experiences working together can be leveraged to prepare for a potential second wave of the COVID-19 virus, and to deliver better-integrated care to your patient population more broadly within Year 1. In your response, please identify which members of your team have long-standing working relationships, and which relationships are more recent.

Max word count: 1000 All members of the West Toronto region have demonstrated a history of formally and informally working with one another to advance integrated care. Examples include the

integrated COPD pathway, West Community Connect, Toronto Long-Term Vent Strategy, virtual interprofessional health team that supports primary care providers through a single point of access, SCOPE, collaboration among primary care and acute care to support the COVID-19 Assessment Centre, collaboration between CHCs and Primary Care to support PPE access and between CHCs and acute care to support mobile testing in congregate settings.

Some of these initiatives have included formal agreements such as MOUs, as well as commitments to integrated QIPs between organizations. We continue to collaborate with Home and Community Care-Toronto Region to leverage the neighbourhood care models for care coordination and system navigation as well as embedded care coordination in primary care in West Toronto.

Beyond the Steering Committee partners in West Toronto, a number of organizations are actively engaged in West Toronto. They collaborate as members of the working groups focused on the priority populations or through participation in larger engagement meetings to discuss and inform the development of the OHT overall. These organizations form the West Toronto Collaborative, and are listed in the supplementary excel file.

Since the pandemic began, providers across West Toronto have been working together to support patients and to share processes, resources, best and leading practices and information. At the height of the pandemic, the West Toronto Collaborative team was meeting weekly to exchange information and support. We have been supporting each other through sharing of PPE; sharing practices and protocols related to IPAC, occupational health and safety, human resources, reopening and other essential topics including on-site and mobile testing and isolation sites. We held joint IPAC training sessions with Home and Community Care to support leadership and frontline staff with important information on IPAC protocols. We continue to hold these collaborative meetings on a regular basis to discuss topics of interest responding to needs identified by the collaborative. Through this work, we have built a stronger network with the collaborative and other partners including the City of Toronto and patients, families and caregivers.

“As a community based organization, Village FHT relied on the PPE and IPAC advice from the experts at Unity Health. I appreciated speaking directly with an infection control expert about our specific work setting questions. We learned a lot and made changes to our workflow and policy based on her advice. As a result, our work place is safer for team members and patients.” Diana Noel, Village FHT

Of particular note, several new partnerships have formed and strengthened through the pandemic. Many cross-sectoral organizations have been supporting seniors at

home and in congregate settings. Before the pandemic, we had few relationships with long-term care homes (LTCHs) and retirement homes (RHs) caring for frail seniors. These relationships have significantly grown during the pandemic in collaboration with Ontario Health – Toronto Region, Home and Community Care and Toronto Public Health. Our response included St Joseph's assisting nine LTCHs and six RHs, supporting 1,953 residents. Our response to the COVID-19 pandemic has expanded to include the following services:

- Infection Prevention & Control and Environmental Services: through risk assessment, recommendations and support to implement recommendations based on best practices
- Personal Protective Equipment (PPE): Rapid response to PPE need, including supply allocation (access, levels, education, conservation)
- Human Resources: support to ascertain critical staffing needs and access to necessary supports and associated training as well as implementation of policies and directives such as return to work
- Testing: knowledge transfer and training of 9 CHC nurses from the COVID Assessment Centre at St. Joes, including NP swabbing and IPAC to enhance a mobile assessment team to support rapid COVID-19 testing in congregate settings.

"This outbreak stretched way too long. I just want to say one more time, how grateful Norwood's Team is of the amazing support we have received from St. Joe's Team in the past two months". Sara Acuna, Norwood LTC

Our integrated pandemic response to support people with mental health and addictions needs includes:

- Sharing of best practices on phone and virtual service delivery among mental health and addictions providers during Collaborative meetings across the WT region.
- Partnership between HSPs who have received COVID Relief Funds from other funders to develop new counselling programs to support the population.
- Collaboration between hospitals and MHA providers to ensure mobile testing in high supports housing for people with MHA needs, which will need to continue to respond effectively in limiting spread of infection.

We also held regularly scheduled sessions with a growing network of primary care providers in West Toronto (40-60 participants across various models of primary care: solo physicians, FHG, FHO, FHTs and CHCs) to provide guidance, share information, both from specialists and enable sharing amongst them. LTC physician leads provided information and supports to primary care physicians and those physicians working in LTCH and RH settings. More than 12 physician-to-physician engagements have taken place from March 2020 to August 2020. Specialized clinical supports through IPAC, Specialized Geriatric Services, LTC+ West for specialized services and

palliative care supports in West Toronto were also developed to support physicians in LTCHs and RHs.

Building on this momentum, members in West Toronto are working collaboratively to develop a COVID-19 Wave 2 response leveraging lessons learned so far to help us prepare for a potential second wave. We have also collected information from the members through survey on their experience and lessons learned during the pandemic. We will be using the information collected from our collaborative and engagement with our patients, families and caregivers to inform our continued response to the pandemic.

One West Toronto wide regional initiative will be the development of a regional influenza vaccination plan, led by primary care and acute care in collaboration with patients, caregivers and families and the other providers; our implementation plan takes into account our experience during the first phase of the pandemic.

3.0. Leveraging Lessons Learned from COVID-19

3.1. Has your response to the COVID-19 pandemic expanded or changed the types of services that your team offers within your community? (this may include ED diversion services such as telemedicine or chronic disease management, in-home care, etc.)

3.2. Do you anticipate continuation of these services into the fall? If so, describe how partners in your proposed OHT will connect services and programs with each other to improve patient care

Max Word Count: 500

At the onset of the pandemic, many providers were not equipped to support in-person visits and many did not feel comfortable managing patients on site. Services were scaled back for community providers and many pivoted to virtual care using OTN, MS Teams, Zoom, FaceTime etc. to provide services. We learned that many patients were socially isolated, and others delayed their care or did not receive care leading to deterioration of their condition.

“Pre-COVID my days were filled with social engagements (lectures, exercise, fitness, therapy etc) but it was the people contact that was important to me.” Patient in West Toronto

West Toronto members organized weekly meetings to understand and respond to the pulse of the community. Partnerships evolved within and across sectors, for example the City of Toronto, food banks, United Way, volunteers, IT companies, Toronto Community Housing, community groups and faith groups addressing food security and digital connectivity.

"I am really grateful to have a phone and be able to have that much of a connection to the rest of the world." Patient in West Toronto

We learned about the value of communication in keeping members abreast of the situation and in fostering collaboration and sharing information and practices such as IPAC, PPE, and scripts for telephone check-ups.

We also understood the pandemic had an impact on vulnerable populations (seniors, those precariously housed, people in congregate living, and people with disabilities) and contributed to health disparities, food insecurity, emotional distress and increased risk of MHA for individuals and the community.

"All the "How did we do with COVID" surveys were on the internet, so I could not let them know that internet access is not universal because it is not affordable and the most needy of us is stuck without it and we are the ones who needed help the most ... so there is a BIG HOLE remaining in everyone's preparedness plans." Patient in West Toronto

As we plan for a potential second wave, we are prioritizing these vulnerable populations to ensure availability of services, in-person as well as virtually. Going into the fall, the team has developed the following initiatives to support the community:

- Supporting providers to deliver services in the most appropriate and safe way and to keep their employees and volunteers safe
- Developing criteria for in-person and virtual care to ensure services are provided in the most appropriate and safe way
- Developing targeted approaches for high risk and vulnerable patient populations
- Leveraging existing care coordination at Home and Community and Community Support Services to develop a coordination model with four hubs in West Toronto
- Coordinated response to patient/caregiver and the community including:
- Coordinated flu vaccination plan
- Residence for isolating/ quarantine
- Respiratory assessment clinic
- Provide support to ensure access to virtual care (equipment/training)
- Collaborating with Ontario Health-Toronto to access IPAC, PPE, education and training for staff, patients/clients and caregivers
- Improving consistency of information to the public and community members in collaboration with patients and families.

4.0. How will you transform care?

In this section, you are asked to propose what your team will do differently to achieve improvements in health outcomes for your patient population. This should include reflections on the lessons learned in response to the COVID-19 pandemic and how your team will deliver a

coordinated response to COVID-19 in the future.

By redesigning care for their patients, Ontario Health Teams are intended to improve patient and population health outcomes; patient, family, and caregiver experiences; provider experiences; and value. By working together as an integrated team over time, Ontario Health Teams will be expected to demonstrate improved performance on important health system measures, including but not limited to:

- Number of people in hallway health care beds
- Percentage of Ontarians who had a virtual health care encounter in the last 12 months
- Percentage of Ontarians who digitally accessed their health information in the last 12 months
- 30-day inpatient readmission rate
- Rate of hospitalization for ambulatory care sensitive conditions
- Alternate level of care (ALC rate)
- Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
- Total health care expenditures
- Timely access to primary care
- Supporting long-term care and retirement homes, particularly in cases of a COVID-19 outbreak
- Wait time for first home care service from community
- Frequent ED visits (4+ per year) for mental health and addictions
- Patient reported experience and outcome measures and provider experience measures (under development)
- ED physician initial assessment
- Median time to long-term care placement
- 7-day physician follow up post-discharge
- Hospital stay extended because the right home care services not ready
- Caregiver distress
- Time to inpatient bed
- Potentially avoidable emergency department visits for long-term care residents

Recognizing that measuring and achieving success on the above indicators will take time, and that teams will be focused on COVID-19 planning and response, the Ministry is interested in understanding how your team will measure and monitor its success regarding the delivery of a coordinated pandemic response, as well as improving population health outcomes, patient care, and integration among providers in the short-term.

4.1. Based on the population health data that has been or will be provided to you, please identify between 3 and 5 performance measures your team proposes to use to monitor and track success in Year 1. At least one indicator/metric should pertain specifically to your proposed priority patient population(s).

Please complete this table in the Full Application *supplementary template*

Performance Measures	Purpose/Rationale	Method of Collection/Calculation
1.		
2.		
3.		
4.		

5.		

4.2. How will your team provide virtual and digitally enabled care?

The provision of one or more virtual care services to patients is a key Year 1 service deliverable for Ontario Health Teams. Virtual care and other digital health solutions enable patients to have more choice in how they interact with the health care system, providing alternatives to face-to-face interactions. This includes virtual visits that allow patients to interact with their healthcare providers using telephone, video or electronic messaging, websites and apps that provide patients with easy access to their health records, innovative programs and apps that help patients manage their condition from their homes, and tools that allow patients to book appointments online and connect with the care they need from a distance. At maturity, teams are expected to be providing patients with a complete range of digital services. Please specify how virtual care will be provided to Indigenous populations, Francophones and other vulnerable populations in your Year 1 population and/or sub-group.

In the context of COVID-19, increasing the availability of digital health solutions, including virtual care, has been critical for maintaining the provision of essential health care services for patients, while respecting public health and safety guidelines to reduce transmission of the virus. Please describe how virtual care was implemented and used to support a response to COVID-19 and your plans to continue providing virtual care. Please also describe what digital health solutions and services are either currently in place or planned for imminent implementation to support equitable access to health care services for your patient population and what your plans are to ensure that patient information is shared securely and digitally across the providers in your team for the purposes of integrated care delivery. Please demonstrate how the proposed plans are aligned and consistent with the directions outlined in the Digital Health Playbook. Responses should reference digital health solutions that both predate COVID-19 (where applicable) and any that have arisen as a result of the pandemic response[4].

Max word count: 500

West Toronto members have a number of strengths and opportunities to build a strong digital ecosystem for providers and patients: all organizations are using an EMR or HIS solution, with some having access to ConnectingOntario while others are implementing electronic referrals using Caredove or Novari platforms. We intend to achieve the digital goals for our OHT by leveraging and streamlining existing tools and technologies used by our partners.

Prior to the pandemic, WT providers began to advance digital health and the following goals were identified:

- Optimize information sharing and collaboration among providers

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[4] By completing this section the members of your team consent that the relevant delivery organizations (i.e., Ontario Health and OntarioMD), may support the Ministry of Health's (Ministry) validation of claims made in this section by sharing validation information (e.g., the number of EMR instances, including the name and version of all EMRs used by applicants) with the Ministry for that purpose.

● Sustain, improve and expand where appropriate virtual care offerings
● Enhance patient engagement through digital channels

In addition, we require the following foundational enablers to meet the goals of the OHT:
● Mechanism to identify and follow patients
● Establish the data governance model
● Harmonize security and privacy policies
● Develop a data-driven approach to population health management

Reflecting on our experience with the pandemic, we are exploring the following key priorities for Year 1:
● Sustain, improve and expand where appropriate virtual care offerings: Since the pandemic emerged, the team has made significant gains with increased adoption of virtual care tools. A number of members implemented other virtual solutions that OHT will investigate for expansion specifically with tele-home monitoring and secure communications with providers and patients. With the shift to virtual care during the pandemic, many providers reported a drop in no show rates as transportation and childcare, which used to be issues were not issues with virtual care. Virtual care also allowed those who have challenges with deconditioning to continue treatment in the comfort of their home. While the shift to virtual care enabled continuation of care, it also perpetuated health disparities for individuals as outlined in section 1.3 above.
● Implement digital pathway to support communication and collaboration of providers and patients through a pilot project: leveraging an existing vendor relationship to integrate data across the care continuum, consolidate documentation and streamline collaboration and communication for providers over virtual channels to accelerate patient throughput with digital pathways. Additionally, enrolling patients' identified on this pathway into MyChart to ensure patients have access to their own health information.
● Leverage provincial and regional solutions: Ensure organizations and providers are being on-boarded solutions like ONEID bundle and ConnectingOntario to share and access patient information. The region is committed to working with provincial members to adopt and advance common solutions that support the OHT model. We are also ensuring that our work is in alignment with digital health work happening on the regional level.

We are committed to building out our broader multi-year digital strategy that will leverage the year 1 goals. This will include establishing a digital governance structure, identifying resources to support the implementation of year 1 goals and establishing implementation plans for year 1 priorities. The members collectively commit to move forward digitally and embrace the opportunity to work with provincial partners and other OHTs to ensure alignment of common tools.

Contact for digital health *Please indicate an individual who will serve as the single point of contact who will be responsible for leading implementation of digital health activities for your team*	Name: Anne Trafford
	Title: Vice President, Quality, Performance, Info Management & CIO, Corporate Resources
	Organization: Unity Health Toronto
	Email: Anne.Trafford@unityhealth.to
	Phone: 416-360-4000 x 5766

4.3. How will you address diverse population health needs?

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

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

4.3.1. How will you work with Indigenous populations?

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

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

If there is a First Nations community in your proposed population base, what evidence have you provided that the community has endorsed this proposal? If your team's attributed population/network map overlaps with one or more First Nation communities [https://www.ontario.ca/page/ontario-first-nations-maps], then support from those communities for your team's application is required. Where applicable, please indicate whether you have support from First Nation communities. Indicate the nature of the support (e.g., letter of support, band council resolution, etc.). If you do not have support at this time, provide detail on what steps your team is taking to work together with First Nations communities towards common purpose.

Max word count: 1000

The West Toronto region is home to 1900 persons of aboriginal descent (Toronto Community Health Profiles Partnerships, 2016). The following neighbourhoods: Junction Area, South Parkdale, Runnymede-Bloor West Village, Roncesvalles, Rockliffe-Smythe and New Toronto have the highest percentage of Indigenous population (Toronto Central LHIN, 2016).

Within our geography there are no identified First Nation Communities, however, Toronto's First Indigenous Health Strategy Report (2016) indicates that 1.3-2.7% of Toronto's population are Indigenous.

Toronto has the largest and most diverse urban Indigenous population in Ontario (Environics Institute, 2010). While there is little local data on Indigenous health, national and First Nations databases indicate that Indigenous people fare worse than the non-Indigenous population on many health indicators (Gionet & Roshanasfshar, 2013; Olding et al., 2014). Indigenous people living in Toronto face challenges across the social determinants of health, and barriers in accessing health services, which have been further exacerbated during the pandemic. Indigenous people experience higher rates of poverty, unemployment, homelessness, involvement with child welfare, food insecurity and challenges within the education system – all contributing to poor health outcomes (McCaskill et al., 2011; NCCAB, 2013; Olding et al., 2014; Steward et al., 2013).

Toronto's First Indigenous Health Strategy (2016) highlights that reducing health inequities experienced by Toronto's Indigenous community requires a coordinated and wholistic approach – one that harmonizes traditional and mainstream health programs and services.

Following the principle of self-determination, we recognize the need for and the value of Indigenous governed and led providers, supporting the delivery of culturally appropriate and safe health services to address the needs of the large and diverse urban Indigenous community in West Toronto. At the time of our initial application, we were in discussions with Anishnawbe Health Toronto to explore how we could collaborate to ensure we address the Indigenous population needs in West Toronto. Anishnawbe Health has made further progress with Indigenous partners and communities and is working to establish an Indigenous Health Team in the GTA. We will be actively participating in their key stakeholder engagement in the coming weeks and look forward to continuing to work together.

Anti-Indigenous racial discrimination and bias have profound negative impacts on the health and wellness of Indigenous communities in Ontario. Health service providers

in West Toronto have participated in Indigenous Cultural Safety online learning to increase respect and understanding and to address anti-Indigenous racial discrimination.

The WT OHT PFAC will be putting together a list of requirements for future additions to the PFAC and Working Groups. Indigenous representation is critical to our success, and through our partnerships, we will request from the community how this can be most successfully achieved. We recognize that Indigenous service providers and community members in the GTA intersect with a number of OHT's, demanding a collaborative approach to planning, partnership and service delivery.

4.3.2. How will you work with Francophone populations?

Does your team serve a designated area or are any of your team members designated under the *French Language Services Act* or identified to provide services in French?

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

Max word count: 500

There are 6210 Francophone in our area: 12% of the Francophone population are under the age of 19, which is lower than the general population in West Toronto (19.4%). 6% are seniors (65 years and over) and 5% are 75 years and older, both lower than the general population in West Toronto area (16.6% and 7.7%, respectively) (Health Analytics Branch, LHIN and Sub-Region Census Profile, 2016, Network 16- Population Health Data, 2017/18).

The Francophone population is increasingly diverse and multicultural in the West Toronto area, one in three Francophones identifies as a visible minority. French is in the top three languages spoken at home other than English in the neighbourhoods of Runnymede-Bloor West Village and Kingsway South.

Our OHT is located in the City of Toronto, which is one of the 26 French Language Services (FLS) designated areas in Ontario. Two identified providers under the French Language Services Act (FLSA) are located in West Toronto area and they are Breakaway Addiction Services and the Toronto Region Home and Community Care.

The WTOHT ensures alignment with the Guide to Requirements and Obligations Relating to French Language Health Services to develop mechanisms to address the needs of its local Francophone community, including the provision of information on local health services that are available in French and in general, better serve Francophones and improve access to linguistically and culturally appropriate services. Our team adheres to the requirements of the FLS Act. We have connected with the French Language Health Planning Entity to assist us in planning to meet the needs of the French-speaking community in the region as confirmed in our Self-Assessment submitted to the ministry earlier last year. Our team will continue to endorse the obligations and responsibilities to French Language Services by applying a Francophone lens when planning and delivering health services in order to improve Francophones' access to appropriate care.

In 2019-20, 64% of our partners in WTOHT had completed the Human Resource Capacity Plan section of their required FLS report, 287 Francophones were identified as 'French-speaking', and received services across the 14 health service providers.

The West Toronto Steering Committee members participated in the Leadership Training on Active Offer, organized by Les Centres d'Accueil Héritage on March 25, 2020. This ensured that our members were made aware of the principles of Active Offer to support the needs and demographics of the Francophone population in Year 1 and at maturity. The principles of Active Offer and identification of Francophones will be implemented in Year 1 and at maturity to ensure that Francophones have equitable access to and culturally safe services. The WT OHT PFAC will put together a list of requirements for future additions to the PFAC and Working Groups. Francophone representation is critical to our success with this community.

The WTOHT members will continue to leverage collaborative approaches with the French Language Health Planning Entity and the designated providers, Le Centre Francophone du Grand Toronto and Les Centres d'Accueil Heritage and will actively offer its services in French.

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

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

Max word count: 500

The West Toronto region has been impacted by gentrification, including rapidly rising housing costs, decreasing availability of affordable rental units and rooming houses as well as infrastructure issues for connectivity to the internet. Many buildings and neighbourhoods are not equipped with internet connectivity, which affects virtual care in certain regions. The area is affected by the long-standing health system planning fragmentation in woefully underserved Etobicoke, creating gaps in service availability and unintended barriers to access. When considered alongside the vulnerable populations, this creates multiple vulnerabilities and in turn affects health outcomes and non-health outcomes.

Specific other population groups that we will be working or supporting include those with low income, newcomers, refugees, people with disabilities, uninsured population, precariously housed patients in Year 1. They were identified as being left out during the first pandemic due to their economic and social conditions. We also noted an increase in Mental Health and Addictions Needs for these groups due to the pandemic.

"You can't always think of things to do on your own. The Art Kits from Dorothy Ley come with instructions that are easy to follow and gets your artistic juices flowing. The activities free your mind and allow you to express your emotions in a safe and positive manner. It gives me something do when there really is very little do in this pandemic". Patient in West Toronto

Using available population data and lessons learned during the pandemic, we will continue to integrate supports and service delivery for marginalized and vulnerable individuals and populations, within our year 1 priority populations and across West Toronto to identify and address poorer health and non-health outcomes.

The social determinants of health are the economic and social conditions that influence individual and population differences in health status. We will continue to partner and collaborate to strengthen local and regional partnerships addressing social determinants of health and healthcare services including: access to care, food insecurity, social isolation, digital inequity, access to COVID-19 testing and self-isolation (through mobile teams and outreach to high risk communities, shelters, congregate settings, LTCHs & RHs).
Examples of these collaboration initiatives include a community client transportation program that was rapidly reengineered to deliver food and pharmacy supplies, food hampers within the community, and the distribution of phones and tablets to vulnerable clients.

"Just wanted to say a big Thank You to LAMP and Good Food boxes for the fresh vegetables. It has been a struggle to find fresh ingredients for my daughter's medical

diet, both financially and availability-wise. We were able to make fresh carrot, orange, apple, celery and garlic juice."- EarlyON Patient in West Toronto.

We will consider new data and identify emerging issues in prioritizing meeting the needs of vulnerable and marginalized communities. We will also align our framework with the work on Equity, Inclusion, Diversity and Anti-racism in development at Ontario Health.

4.3.4. How will your team work with populations and settings identified as vulnerable for COVID-19 and influenza?

Describe how your team intends to deliver supports and coordinated care to communities and settings in which social distancing and other infection prevention and control practices are a challenge.

Max word count: 500

In partnership with patients, caregivers and families, we will continue to leverage the work highlighted in Section 3.0 and other collaboration undertaken with the current providers, City of Toronto on food insecurity, Home and Community and the partnerships developed with LTCH and RHs during the first pandemic.

A number of initiatives are proposed for Year 1, including:
1. Develop and implement a West Toronto Flu vaccination strategy including communication and implementation plan across providers serving the vulnerable population, by leveraging the work of Toronto Public Health and Ministry of Health. This initiative will assist in addressing the anticipated 50% projected decrease in vaccination capacity in West Toronto physicians' offices and reduced vaccination capacity at Toronto Public Health Clinics.
2. Access to primary care is essential during COVID-19 and the influenza period, however based on the lessons learned from the COVID-19 Wave 1, many vulnerable populations could not access primary care due to closure of clinics and inequity of access to virtual care. The team is proposing to leverage Care Coordination/Navigation Model(s) across Home and Community, CSS, CHC to support primary care in identifying vulnerable population's care needs to ensure there is a connection to care and to support primary care, especially with solo practicing MDs, to respond to the needs of their vulnerable patients.
3. Use of Virtual Visits have increased during the COVID period, however a number of vulnerable populations could not access care virtually, which is an unintended consequence. In order to ensure equity of service, our Team plans to develop a list of high and rising risk population that do not have access to care virtually due to limited or absent access to internet, device or phone. The plan is to leverage system resources (IPADs, Phone and other IT supports) as well transportation resources for

in-person visits across the partners to support the vulnerable population in accessing care during flu and COVID-19 Wave 2.
4. Based on a survey conducted among primary care providers in West Toronto, 50% indicated that they would not be able to assess patients due to their current PPE supplies, IPAC measures and social distancing in their offices. Discussions are underway with CHCs, hospital and primary care providers to develop Respiratory Assessment Centres in West Toronto. Unity Health Toronto has developed a plan for a Respiratory Assessment Centre attached to the ED to provide a one stop-shop in and out service to patients with respiratory illnesses. Other community options for Respiratory Assessment are being considered.
5. Integrated service delivery models in the community: This is a collaborative among CHC, CSS and acute sector in the WT region to implement clinics such as geriatric clinics in the community for vulnerable seniors to access care closer to home.
6. Leverage HCC to implement a navigation and care coordination model to ensure that patients do not fall between the cracks during transitions among providers and ensure a continuity of care and information between services among providers.

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

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

Max word count: 1000

WT is committed to patient/client, caregiver and family partnership contributing to the work of the developing OHT to gain a deep understanding of what matters to them in their care and experience and to co-design a better system that is more patient and caregiver/family-centered. Our approach to co-design is to ensure that patients and caregivers actively participate from problem definition to identifying options and developing creative solutions. We believe that active partnership with patients/clients, and caregivers will enable us to create new ways of caring for the population of WT that will improve their experiences and outcomes.

All members of our region have a history of patient partnership and community engagement through Patient Family Advisory Councils, patient and family representation on Board committees, and working groups. We are leveraging these existing networks to involve patients, families and the community in the most meaningful way in our work.
We established a patient and family partnership-working group that includes 5 patient and family advisors and 2 health care providers. This group has been meeting since January and has acted as an interim patient and family advisory committee for our developing team. This group is co-lead by a patient/caregiver partner. Our patient/client, caregiver and family partnership work to date includes:
● Provided feedback and input into the vision and guiding principles to ensure they reflect the patient and family perspective.

● Helped to identify and support patients and caregiver partners to participate on all working groups, steering committee and planning teams.
● Completed an inventory of our health partners to determine how many have a PFAC committee and will be developing a plan for how to engage them in the work.
● Gathered input from patient and caregivers on advisory councils of some of the partner organizations in the region.
● Developed the approach to patient and family partnership including guiding principles.
● Our patient and family partners have participated on our West Toronto region COVID-19 Collaborative calls and have brought forth issues pertinent to patients and families such as visitation in LTC, hospitals and other settings.
● Our patient and family lead participated on regional planning tables related to visitation and brought forth guidelines and best practices to the West Toronto region.
● Informed the planning for COVID-19 wave 2 by identifying areas of importance for planning from a patient and family perspective. This information was shared with the West Toronto Steering committee and all working groups.

Our patient/client, caregiver and family partnership approach is guided by the following principles:
● Ensuring we have a diverse representation of patients/caregivers and families that reflect the diversity of the West Toronto community, diversity of background, diversity of experience and perspective including diversity of experience with the health care continuum/health care settings.
● Ensuring we hear from all communities in West Toronto by using a community development/engagement approach. This means we will collaborate with local health and social care providers and informal leaders to engage with and seek feedback from the various communities in West Toronto.
● A commitment to using a variety of engagement approaches that include focus groups, surveys, town halls, attending community centre events, etc.
● Commitment to transparency and communication with those we collaborate with, and seek feedback from, on how their participation/input is making a difference.
● Educating and supporting transformation in terms of patient and caregiver engagement and partnership. This includes educating health care partners and supporting them on how to collaborate with patients and families in the West Toronto region. We should model patients and health care providers working together which is key for the transformative change we are hoping for in health care
● Commitment to removing barriers to patients/clients and families to being true partners such as ensuring reimbursement for travel expense, provision of food if meetings are over the meal hours, support for respite for caregivers, stipend for patient and advisors working on steering committees/working groups making our region a welcoming partnership.

For Year 1 of the West Toronto region, we commit to the following:
1. Establish the infrastructure for Patient/client, caregiver and family partnership for West Toronto region. This includes:
● Establishing a Patient and Family Advisory Committee (PFAC) for the West Toronto region. We will ensure diverse representation to ensure the committee reflects the people of West Toronto.

● Ensure that patients and families have equal voices in decision making/governance and are on decision making/governance committees.
● Ensure all working groups/committees have patient and family partners. One patient/family member from each working group will sit on the West Toronto region PFAC so we can share information among working groups and with the main PFAC.
● Develop a reference guide and undertake education for West Toronto health providers on patient and family engagement and partnership to increase capacity and knowledge on these skills across West Toronto region partners.
2. Contribute to the communication plan with the intent to support the creation of common communication tools on how to help patients/families navigate services in West Toronto region.
3. Contribute to the creation of common communication resources for people in West Toronto with respect to a potential phase 2 of COVID-19.
4. Contribute to the planning for Wave 2 of COVID -19 and the flu season to ensure that what is most important to patients/clients, caregivers and families is reflected in the plan.
5. Support each West Toronto region work group to seek feedback/input from a broader group of patients/clients, caregivers and families as part of their work.

We will develop success criteria for our patient and family partnership approach. Our success criteria includes:
● patient and family partner representation on every working group and planning meetings for West Toronto;
● extent to which patient and family input is reflected in the decisions, plans and activities of West Toronto;
● number of patient/family engagement activities and the number of participants in these activities.

We also plan to survey our patient and family partners to understand their experience and contribution to the work of the OHT.

5.0. Implementation Planning

5.1. What is your implementation plan?

How will you operationalize the care redesign priorities you identified in Section 3 (e.g. virtual care, population health equity etc.)? Please describe your proposed priority deliverables at month three, month six, and month twelve. Priorities and deliverables should reflect performance measures identified in section 4.1.

Note that the Ministry is aware that implementation planning will likely be affected by the trajectory of the COVID-19 pandemic, and applicants will not be penalized should the priorities identified within this section need to be adjusted in future as a result. In anticipation of this likelihood, responses should therefore be reflective of the current health sector context and include contingency planning for ongoing COVID-19 pandemic activities.

Max word count: 1000

In partnership with patients, families and caregivers, providers and other collaborative partners in region, we have developed a robust work plan for each work stream to operationalize the care priorities and support patients, families and caregivers in innovative ways across West Toronto.

The summary below highlights the proposed deliverables at three, six and twelve months in year 1 across the priority populations and initiatives.

Three-month deliverables:

Our attention in the first three months includes responding to the combined pandemic and flu wave. As such, we are developing a number of deliverables focused on assisting West Torontonians in accessing services during these months. This includes establishing the Patient Family Advisory Council (PFAC), ensuring patient and family partners guide this work, through participation in all working groups/committees, and promoting timely communication updates to our patients, collaborative and community members on the next pandemic/flu wave. In order to support access to flu vaccination across our neighbourhoods, we are currently developing a West Toronto flu vaccination strategy in collaboration with Ontario Health-Toronto Region, Public Health to ensure reliable delivery of vaccines, and with primary care and pharmacists to ensure flu vaccination clinics are available to our residents as well as to students in schools. We will also establish a Respiratory Clinic at St. Joe's to ensure services are available when needed and will plan for and implement community respiratory clinics.

Based on lessons learned from the first pandemic wave, we will continue to support LTCH/RHs for testing staff and residents, enabling their plans for surveillance testing. In collaboration with the St. Joe's COVID Assessment Centre and CHCs, we are enhancing capacity for increased mobile testing to ensure testing is available for vulnerable populations and settings across the community.

As part of the digital work, we will work with providers to assess and implement potential solutions to address service gaps in the first wave. This will include continuous collaboration with the City Clusters to ensure accessibility of phones and other digital devices to the patients and enhancing OTN registration and other digital supports in the community to ensure services are available to the most vulnerable.

One of the main deliverables of the Governance WG will be to develop a CDMA in partnership with our collaborative members in West Toronto. Each working group will finalize their year 1 plans, including implementation specifics and measures of success. We will also continue our engagements with primary care providers (FHTs,

FHOs, FHGs, Solo practitioners as well as CHCs) and those physicians providing care in LTCHs/RHs toward building an integrated system with primary care across West Toronto.

Through this period, we will look for an impact on reducing avoidable ED visits and increasing virtual health care encounters, noting that there is a lag in data reporting for these two indicators.

Six-month deliverables:

A number of care redesign activities are planned to take place during the six-month period, including:

- developing a reference guide and undertake education for West Toronto on Patients, family engagement and partnerships;
- improving virtual care delivery across West Toronto;
- re-designing primary care access and navigation to supports by streamlining referral patterns, eligibility for LTC+ and SCOPE
- ensuring clear criteria are in place for virtual care and in-person care across settings;
- expanding our communication and engagement efforts to reach other stakeholders, such as physicians not currently represented by any of the working groups
- testing processes and procedures, frameworks in collaboration with Home and Community, Primary Care as well as other providers in one neighbourhood in West Toronto ;
- developing a Quality Improvement and Performance Plan for the work underway to ensure a quality lens as well as defined success measures are in place to monitor impact of the care redesigns;
- implementing work plans across the Working Groups

As noted previously, a number of frail seniors were further isolated and experienced decreased access to services during the last pandemic. We are planning to implement specialized geriatric clinics, a collaboration between hospital and community providers, in two neighbourhoods with a high density of seniors – bringing typically hospital delivered services into the community and closer to home.

We will continue with surveillance testing in LTCH/RHs as well as in community congregate settings.

Through this work, we hope to see a further impact on ED visits, ALC and percentage of the population who had a virtual health care encounter, noting that there is a lag in data reporting for these indicators.

Twelve-month deliverables:

At 12 months, we intend to complete all the activities identified in the Year 1 work plans across the working groups in West Toronto, which include:

- established PFAC in West Toronto
- a digital pathway solution to support communication and collaboration among providers and patients
- an established clinical pathway to support COPD patients in community pulmonary rehabilitation
- an integrated model of care for frail seniors across of all settings including primary care
- a framework implemented for Mental Health and Addictions, leveraging recommendations from Ontario Health - Toronto Region on Addictions and a test of change undertaken in South Parkdale for Mental Health and Addictions
- collect race-based socio-economic data to understand whom we serve and where there are poorer health outcomes, as described in Section 1.3
- a performance scorecard to support and monitor all the care redesigns undertaken with reported performance indicators

We will measure the impact of this work through change in all 4 indicators identified in Section 4.1, noting that there is a lag in data reporting for some of these indicators. We will look to the results in year one to establish a baseline for targets moving forward in the coming years.

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

Please identify what centralized resources or supports your team would need to be successful in the coming year, if approved. This response is intended as information for the Ministry and is not evaluated.

Max word count: 1000

Data and Analysis:

As the West Toronto continues its work to best understand the needs of the people we serve, identify priority populations for subsequent years and to assess the impact of our work, we would benefit from analytical support. Of particular interest, our partners are really focusing in on equity. We see great value in working closely with the Toronto City Clusters and will leverage the additional data and reporting coming out on inequities in our area. We are also looking at leverage the Analytics Team at Ontario Health, Toronto Region, who is well versed in the available data sources and has strong analytical capabilities that would enhance our ability to do this work. It would be highly beneficial to have access to data and analysis support.

Public Health Partnership:

As we plan to provide a coordinated response to Wave 2 of COVID, it would be very helpful to have strong connections with Toronto Public Health. Both at a planning and coordinating level to enable strong response from testing to flu vaccinations. We also see the response needing to be coordinated across all providers, many of who are small or independent and do not have sufficient or enough coordination support. Access to additional project coordination support would be extremely valuable.

Regional Planning across OHTs:
Facilitation of Toronto wide planning across OHTs would be very helpful. While we are all working to create stronger linkages amongst the providers in our community, we know that many of our providers, serve a population broader than our local community, and we also know our patients and clients access care across Toronto (and beyond) and so it is important, when we can, for our approach to be in line with approaches of other OHTs across the city. In addition to this, it would be very helpful to leverage learnings and avoid duplication of effort to address challenges that have been solved or are being solved in another OHT.

Expert Consultation on Anti-Black Racism and BIPOC policies:
Based on Section 1.3 and focused on equity principles, the West Toronto region team would appreciate some expert consultation and findings on Anti-Black racism and BIPOC policies to ensure organizations do not duplicate efforts to develop equity based principles and culturally sensitive processes. This is aligned with the Ministry and City of Toronto objectives to support organizations in reducing inherent racist practices.

Virtual Options:
During the first pandemic wave, all organizations turned to virtual care based on their capacity. Health Services Providers' funding did not include virtual care service delivery and many HSPs had to support these virtual options within existing funding. The West Toronto Team would like to have access to consultation on virtual services as well as how to ensure compliance to PHIPPA in order to support safe and consistent patient care.

5.3. Have you identified any systemic barriers or facilitators for change?

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

Max word count: 1000
It is promising that the new Home and Community Care regulations (Bill 175) enable greater opportunities for providers to take on a community care role by modernizing the home and community sector, expanding a more person-centered approach based

on client need. The West Toronto partners have been working in more integrated ways with home and community care in our priority population working groups and welcome these regulations that will help further support this work. We also know that there is a lot we have to learn and explore through the application of the Home and Community Care regulations and we hope it will address many of the barriers that have existed in West Toronto. We look forward to learning more about the finalized regulations through the lens of integrated and collaborative care across Ontario Health Teams.

The work to meet the needs of our attributed population intersects with non-health providers. We are developing stronger relationships with the City cluster tables, co-chaired by City of Toronto and United Way. The separate funding streams do create a barrier to fully integrating responses to meet the needs of our shared population. We would like to have stronger and engaged partnerships with both the City of Toronto and the funded organizations. We respect that it is a challenge for both of those organizations to engage with multiple OHTs. While we are engaging with these organizations, working with Ontario Health-Toronto Region to help navigate and solidify these relationships has been helpful. This is also the case across providers funded through other ministries such as Education and Children, Community & Social Services.

West Toronto has high numbers of solo family physicians, with a further significant impact from upcoming retirements. We believe we have made great progress in engaging physicians through the pandemic by providing a forum to access information from specialists, the COVID Assessment Centre, LTC+ as well as an opportunity for physicians to share approaches amongst themselves. Regardless, there are still challenges because of so few physicians being aware of centralized access to community resources (Longwoods, 2020). We continue to keep primary care as a central part of our work.

In line with this, there are areas of community service gaps e.g. in Etobicoke for community mental health services, which pose additional planning and operational challenges. West Toronto region has the lowest number of funded health service providers delivering Community Support Services and Mental Health and Addictions services across Toronto. While we understand patients access services across the Toronto region, it is also important to note access to services for vulnerable population as mentioned in Sections 1.3 and 4.3.3.

Understanding the impact and planning for attributed populations across the neighbouring OHTs in the dense urban environment in Toronto and more specifically in Etobicoke will be a challenge. The latter region has been historically sub-divided into different regions from a planning, service delivery and funding perspective in Toronto and will include overlap with the attributed population for Mississauga.

The digital infrastructure in West Toronto region is very old with unique barriers such as old connectivity wires, no connectivity in congregate buildings and no specific providers. Access to technology is not available in the old buildings in West Toronto, which create a major inequity of virtual services.

Membership Approval

Please have every member of your team sign this application. For organizations, board chair sign-off is required. By signing this section, you indicate that you have taken appropriate steps to ensure that the content of this application is accurate and complete.

Team Member	
Name	
Position	
Organization (where applicable)	
Signature	
Date	
Please repeat signature lines as necessary.	