Welcome to NORTH YORK

TORONTO, CANADA

North York Toronto Health Partners

Patient and Family Advisors

1100 FHO

Bathurst FHO

Discovery FHO

Fairview FHO

Lawrence Park FHO

New Family Medicine FHO

North York FHO

NYGH FMTU FHO

Alzheimer Society Toronto

Health

North York General

Advent Valleyview Residence

Bayshore HealthCare

ASYR Addiction Services for York Region

BetterLiving at Thompson House

Carefirst Seniors & Community Services Association

Central LHIN

North York General

Freeman Centre for Advanced Palliative Care

LOFT

Circle of Care Sinai Health System

Toronto North Support Services / Les Services de soutien de Toronto Nord

BetterLiving Health and Community Services

Baycrest

North York Family Health Team

North York General Seniors Health Centre

Temmy Latner Centre for Palliative Care

North York General Department of Family & Community Medicine

Cota Inspiring Change

VHA Home HealthCare Creating More Independence

Yee Hong Centre For Geriatric Care 頤康中心

North York Toronto Health Partners

Maggie Keresteci, Patient Caregiver Partner

Welcome to Our Community

Dr. David Eisen, NYGH Chief, Department of Family and Community Medicine

North York is a small town community in an urban setting

North York Toronto Health Partners (NYTHP) was *not* the start of our partnership

We bring a history of ***trust*** and ***collaboration***, which is a springboard for our initiatives and projects

We are in the process of *making a difference in the near-term* as we plan for *systemic changes long-term*

North York Toronto Health Partners

Our Vision and Values

Dr. David Eisen, NYGH Chief, Department of Family and Community Medicine

Our Vision

North York Toronto Health Partners will:

- Integrate and offer **a full & coordinated continuum of care, rooted in primary care**
- **Continue to co-design with patients, families and caregivers**
- Build on what already exists, including **expanding on current success**
- Move towards **population health management**
- Look to **digital first**

Our Values

Person and Family Centred

Collaborative

Efficient

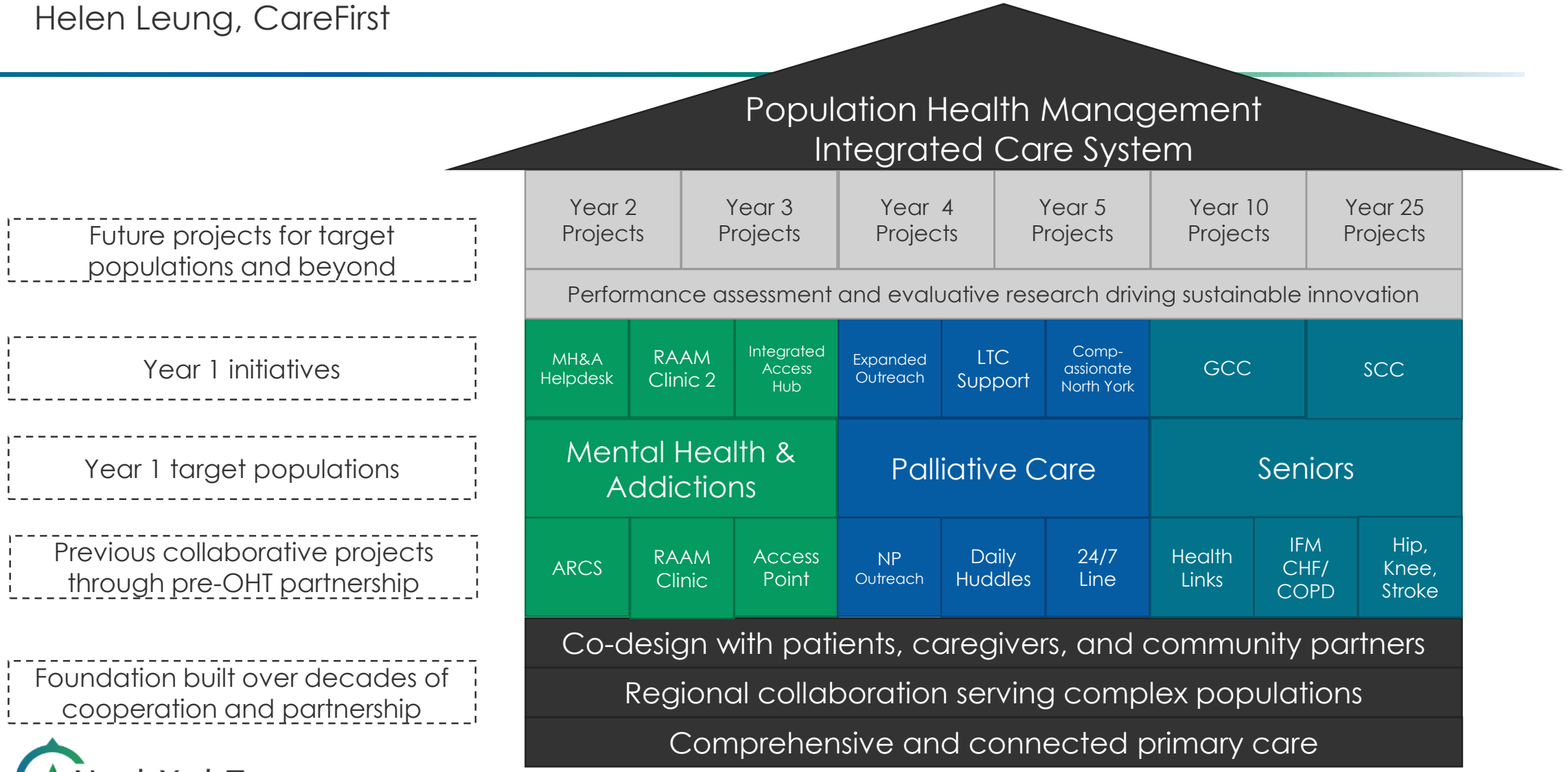
High Quality

Accountable

Equitable

North York: Building on an Existing Foundation

Helen Leung, CareFirst



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Making a Difference in Year 1: Mental Health and Addictions

RAAM Clinic: Penny Marrett, Addiction Services York Region
Integrated Access Hub: Susan Meikle, Toronto North Support Services
Mental Health and Addictions Help Desk: Paul Bruce, Cota Health

Expand RAAM Clinics

Objective: To expand addiction medicine support through a second and third RAAM clinic in the community to provide greater access for those who need addiction medicine options without having to wait

Partners: Addiction Services York Region, NYGH, Central LHIN

Status Update: 1st RAAM Clinic had 48 unique clients since opening in June (133 visits)- 0/12 client files reviewed returned to ED (more analysis needed), 2nd RAAM Clinic Planning- project initiated, exploration of location in community to provide follow-ups

Integrated Access Hub

Objective: Integrate hospital and community access systems, and community-hospital ED diversion partnership (ARCS), to create seamless access to the full range of hospital and community mental health and addictions services

Partners: Toronto North Support Services, Cota, NYGH, Addiction Services York Region, Central LHIN

Status Update: Current state mapped, first draft of common referral form developed, services inventoried. Upcoming: operational requirements objectives and dependencies

Mental Health and Addictions Helpdesk

Objective: To provide on demand navigation options for adults with mental health and addictions issues who need information, support and instrumental help in the North York Toronto OHT.

Partners: Toronto North Support Services, Cota, NYGH, Addiction Services York Region, Central LHIN

Status Update: Developed concept deliverables and year 1 timeline, major milestones determined. Upcoming- finalize location, staffing criteria, communication to clients.

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Making a Difference in Year 1: Palliative Care

Sonya Murray, Better Living
Supportive Homebound Outreach: Wendy Cheung, NYGH
Expanding Palliative Support to LTC: Dr. Desmond Leung, NYGH
Compassionate North York: Ivan Ip, Yee Hong

North York Toronto Supportive Outreach Program

Objective: To better serve the needs of homebound patients with non-malignant, life limiting illnesses through NP and palliative physician outreach model (based on Freeman model)

Partners: Freeman Centre (NYGH), Central LHIN, Home Care providers, Community Support Services

Status Update: NP provided by the LHIN, patient and clinical workflow determined; Upcoming- Cerner Access/Build for Program, Patients to be enrolled beginning Jan 2020.

Expanding access to palliative support in Long-Term Care

Objective: To expand access and capacity for supportive care with a palliative approach in long term care through palliative virtual teams

Partners: Freeman Centre (NYGH), Central LHIN, LTC providers (Yee Hong, Valleyview), Temmy Latner

Status Update: Chart review of LTC underway, project lead and initial team members determined

Compassionate North York

Objective: To create a "Compassionate North York" in order to raise awareness about death, dying, loss, grief and bereavement through a ***Compassionate Community*** lens, and to help inform culturally appropriate palliative and end-of-life and hospice practices.

Partners: LTC providers , Hospices, Freeman Centre (NYGH), Temmy Latner, Local businesses and organizations

Status Update: Overview of Compassionate Communities provided by Pallium Canada, Project Lead and initial team members determined

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Making a Difference in Year 1: Seniors Health

Debra Walko, LOFT
Generalized Care Coordination: Colleen Briggs, CHCC
Specialized Care Coordination: Jagger Smith, Baycrest

Generalized Care Coordination (GCC)

Objective: seamless coordinated home and community care to seniors via generalized care coordination (GCC) aligned to primary care
Partners: Primary Care (practices TBC), Central LHIN, Home Care providers , Community Service providers, Hospitals (NYGH, Baycrest)

Status Update: First Project Team meeting held; Upcoming- understand current care coordination processes, identify and engage PCPs as host/pilot sites

Specialized Care Coordination (SCC)

Objective: seamless coordinated home and community care via specialized Clinical Consultants (SCC) providing overall care coordination responsibilities for seniors who are at rising risk or high risk and experiencing COPF/CHF and Dementia

Partners: Alzheimer's Society Toronto, Primary Care, Central LHIN, Home Care providers , Community Service providers, Hospitals (NYGH, Baycrest)

Status Update: Project Lead determined, meetings scheduled to understand current opportunities to leverage tele-monitoring

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Primary Care Working Group

Dr. Maria Muraca, Medical Director, North York Family Health Team (NYFHT)
Dr. Adam Dwosh, Deputy Chief, NYGH Family and Community Medicine

Key Highlights and Achievements

- Met monthly since May 2019
- **Working group includes 27 members,** including 20 family physicians, North York Family Heath Team, 2 community health centres, representative from the OMA, and a patient/family partner
- Distributed a survey to~450 primary care physicians in collaboration with the OMA with the objectives of:
    1. **Validating our understanding** of the challenges faced by primary care physicians
    2. **Obtaining input** into the key components and governance structure of an OHT that would be most beneficial to primary care
    3. **Gaining interest** in signing up to participate in the OHT
- Leveraged survey results collected from 100 physicians to support our engagement strategy and the identification of year 1 projects

Future Focus

- Create a Primary Care Network to develop recommendations on primary care governance and Terms of Reference
- Develop plans for year 1 projects to:
    1. Utilize and bill for virtual care*
    2. Facilitate access to consultants*
    3. Increase access to allied health professionals and care coordination
    4. Optimize available digital solutions (e.g. OLIS, HRM, Connecting Ontario, eConsult)

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* Sub-committees have been formed and will have inaugural meeting in November

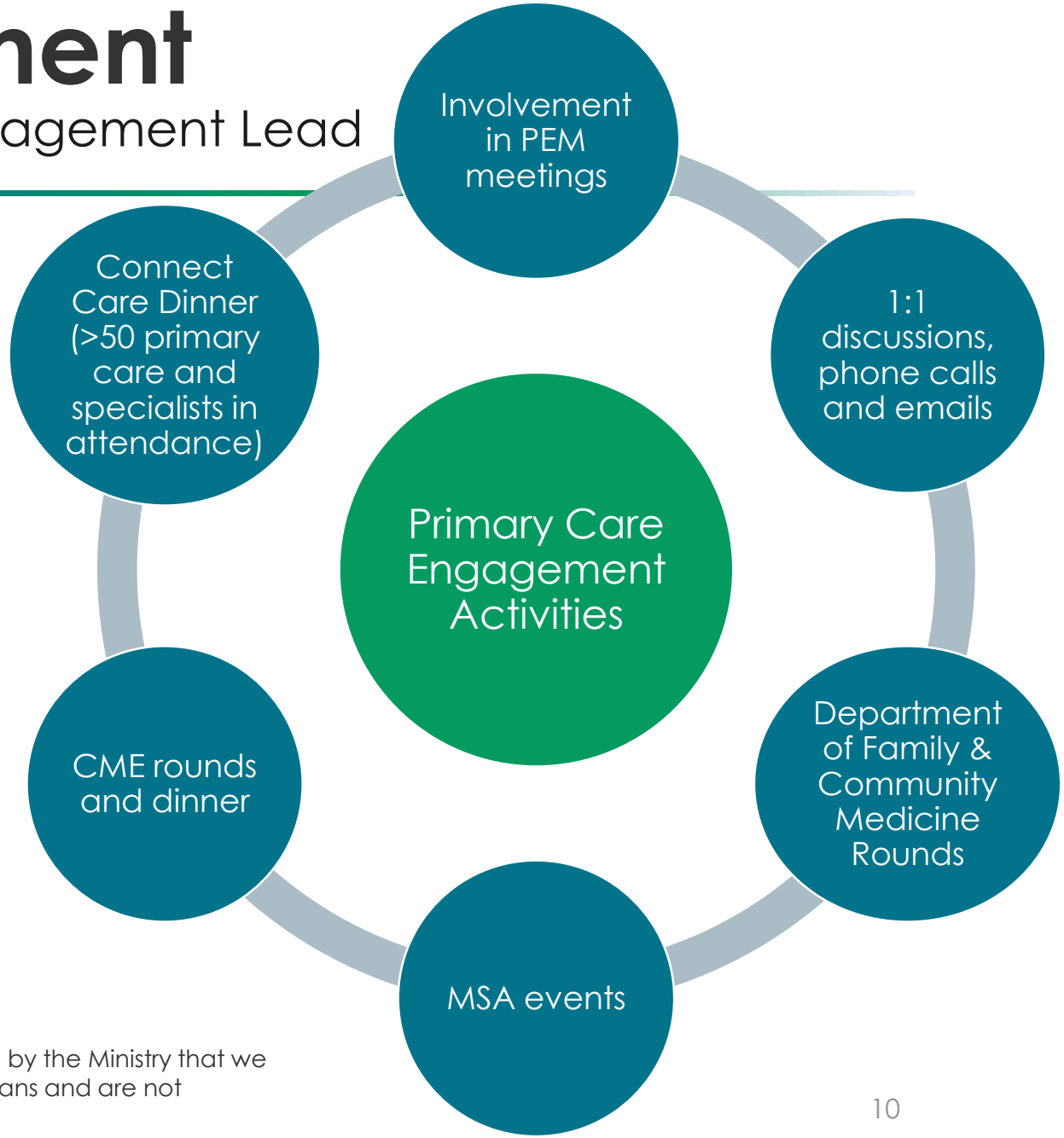
Primary Care Engagement

Dr. Rebecca Stoller, Interim Primary Care Engagement Lead

Identifying Physicians for Engagement

Identified primary care physicians for engagement were a result of physicians who:

1. Responded to our primary care engagement survey (distributed in collaboration with the OMA)
2. Were identified as part of a PEM that was attributed to NYGH/Baycrest (>80% and <80%)*
3. Proactively approached the NYTHP out of interest
4. Were identified as high referrers to the NYGH Emergency Department



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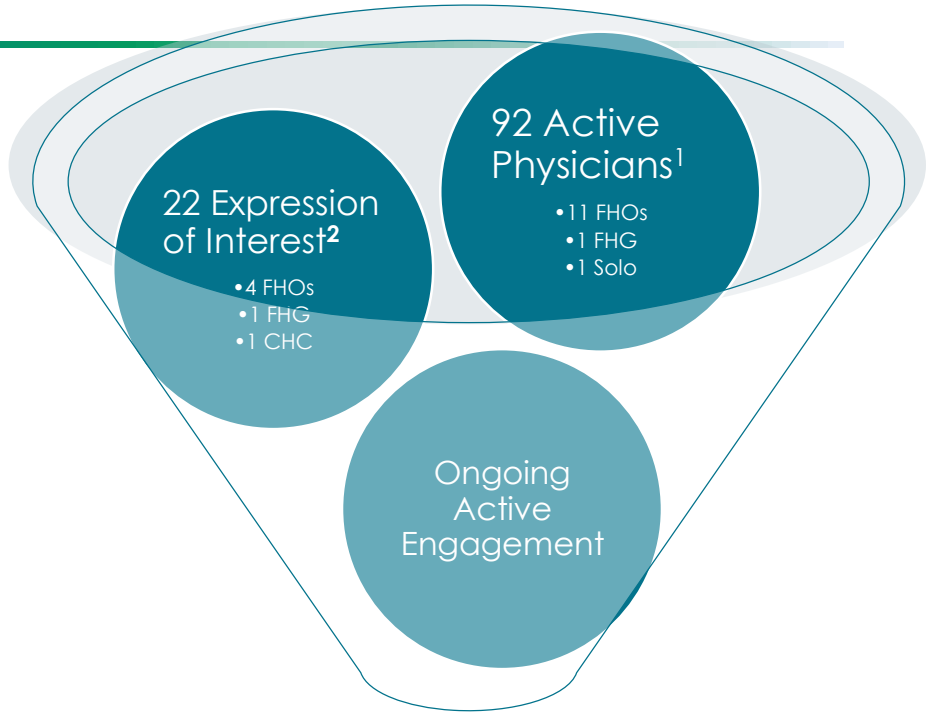
* There were some PEMs on the list provided by the Ministry that we were unable to identify the group of physicians and are not included on this list

Primary Care Engagement

Dr. Rebecca Stoller, Interim Primary Care Engagement Lead

With a target of 203 physicians, over 50% of Year 1 targets have been reached since September 2019



Engagement efforts will continue while adding new strategies such as:

- A monthly newsletter
- Attendance at primary care conferences
- Organization of an event in the new year to bring together primary care providers for a town hall and working session

114 Physicians Signed

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1 – Commitment to participating in the creation of a forward thinking Ontario Health Team . Would like to be an active participant in the design of the North York Toronto Health Partners OHT.

2 - Interested in the creation of a forward thinking Ontario Health Team. Would like to stay informed and engaged in discussions about OHT developments

Patient, Family and Caregiver Engagement

Leela Prasaud, Caregiver Partner

Active Participation in NYTHP's Application Process

- The completion of NYTHP's Self-Assessment
- The completion of our Full Application
- The preparation of today's Site Visit

Continuous Co-Design *Throughout* Implementation

Patient, Family and Caregiver partners are actively involved in ***all*** working groups including:

Year 1 Initiatives
Primary Care
Digital Health
Communications
Governance

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Community Engagement

Christina Campbell, Circle of Care

- **Town Hall Conference Call** (July 2019)
  - ~4000 attendees provided feedback used to understand barriers to accessing care and other feedback from community members
- **Community and Alliance Webinars** (April & September 2019)
  - Provide update and gain insight on application, projects and participation
- **Alliance Meet and Greet** (April 2019)
  - In-person meet and greet for ~60 Core and Alliance Members
- **Home and Community Care Workshop** (September 2019)
  - Collective meeting to understand gaps in home and community care different populations
- **Ongoing support and Engagement with Community**
  - Support from local MPPs and City Counsellors
  - Participation of local services as Alliance partners (Toronto Paramedics
  - Open invitation for community partners to join meetings (Solicitor General's Office)

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24/7 Care Coordination and System Navigation

Karen Fisher, Bayshore

Mental Health and Addictions

- Expand ARCS (ED Diversion) partnership
- Integrated Access Hub to support continuity in navigation and connection with primary and community
- Helpdesk for barrier-free access

Palliative

- Extend Freeman on-call to supportive outreach clients/caregivers
- Integrate and align LHIN 24/7 palliative care line
- Palliative support to LTC to reduce hospital transfers

Seniors

- Specialist Care Consultant on-call to NP and acute team
- Enhanced Generalized Care Coordination 24/7 crisis line and primary care
- Virtual monitoring for CHF/COPD/Dementia

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Plan for Digital Patient Access and Virtual Care

Vision:

"Empower our population to live healthier lives by using digital health technology to create seamless access to health services, education and community support."

NYTHP Digital Strengths	Year 1 Activity	Target Outcome
***Over 80%* of our partners** currently offer some virtual care option (local or OTN)	• Expand access to existing virtual care offerings for year 1 initiatives • Test new virtual care platforms and develop virtual roadmap (e.g. MS Teams)	**>5% of patients** in year 1 population will have received a virtual visit.
~50% of our partners are currently able to provide patients with digital access to their health information	• Increase NYTHP capability to enable patient access to their health records. (e.g. Mychart @ NYGH) • Ensure patient enrollment in OHT year 1 initiatives includes the option to receive electronic access to all or part of their health records	**> 15% of patients** in year 1 will have access to their health records

Foundational activities:

- Implement a federated patient identity model to streamline patient access to all NYTHP services including health records and virtual care services
- Design and implement a centralized access channel for these services
- Launch proof of concept for a client relationship management platform to support coordinated care
- Engage patient champions in solution co-design and implementation planning
- Establish data governance model and harmonized privacy/security policies to address patient access to VC services and centralized access to their health records
- Work with MOH to ensure selected virtual technology has approved billing codes

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Alistair Forsyth, Digital Health

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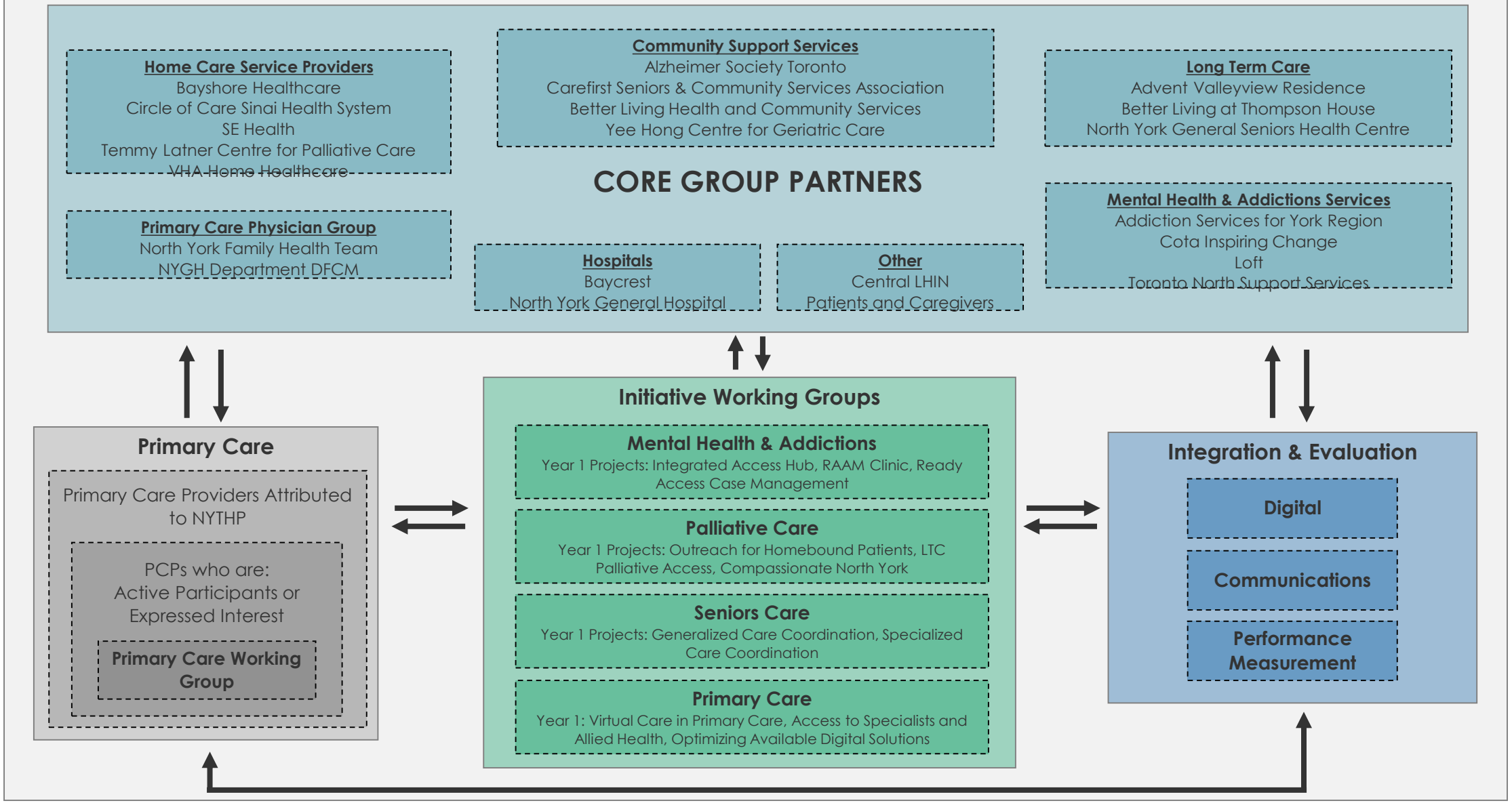

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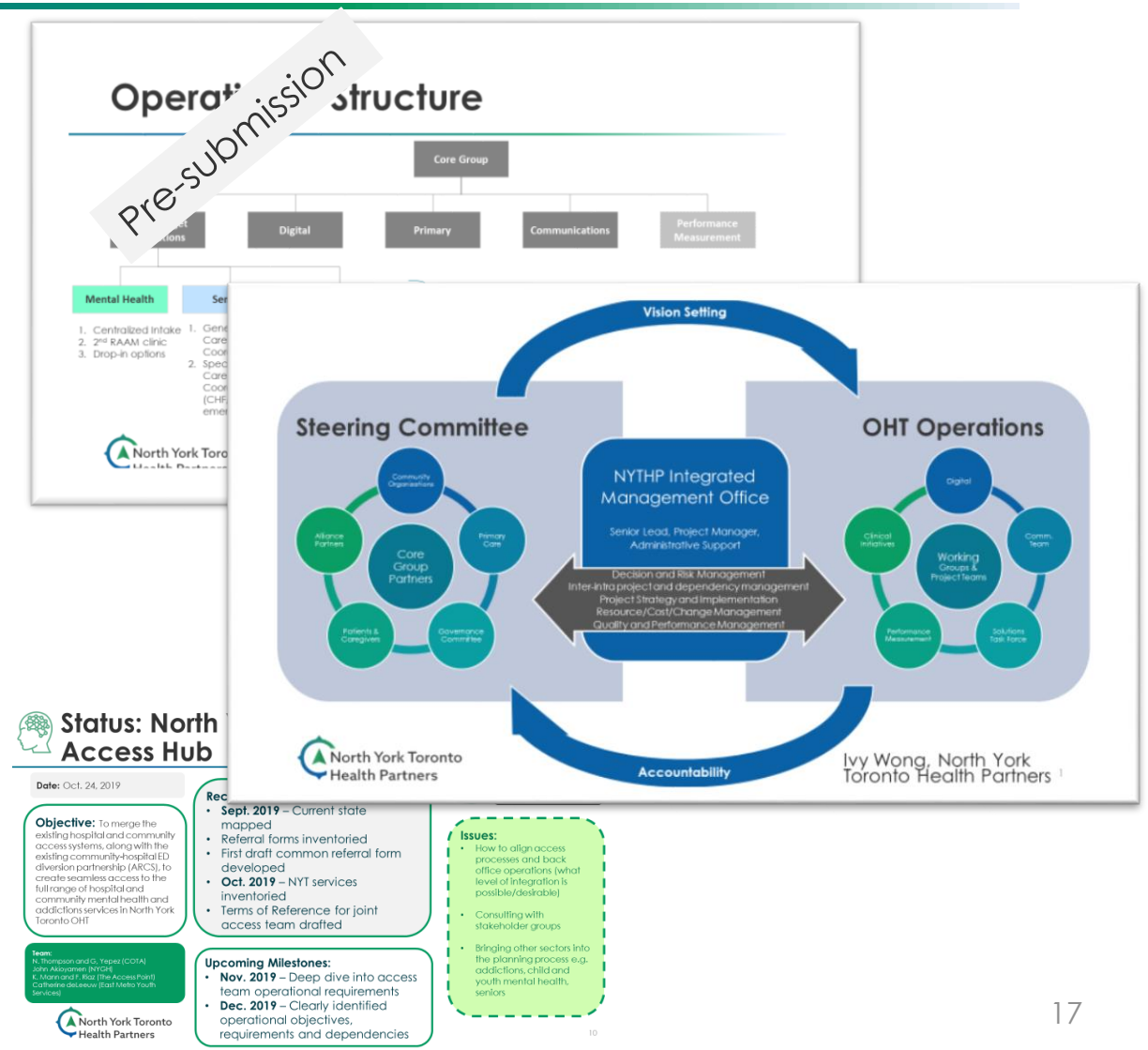
Scott Ovenden, Baycrest

Implementation Progress

Ivy Wong, North York Toronto Health Partners

- Transition from submission preparation Operational Structure to an Integration Management Office (IMO)
  - PMO functions
  - Risk/dependency/change management
  - Cross-project and working group collaboration and alignment
- All 12 Year 1 initiatives have begun
  - Regular Status Updates and team checkpoints
- New working groups being struck:
  - Performance Management and Evaluation
  - Governance
  - Community Engagement
- "Research is a community asset" in North York
  - Joint Data Collaborative + UTOPIAN (Primary Care QI)
  - Advancing the science of iKT (integrated Knowledge Translation)
  - Partnering: BeACCoN, Change Foundation, IHPME



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NYTHP – Successes in Year 1

Kim Leung, Patient Caregiver Partner

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In Year 1, NYTHP will:

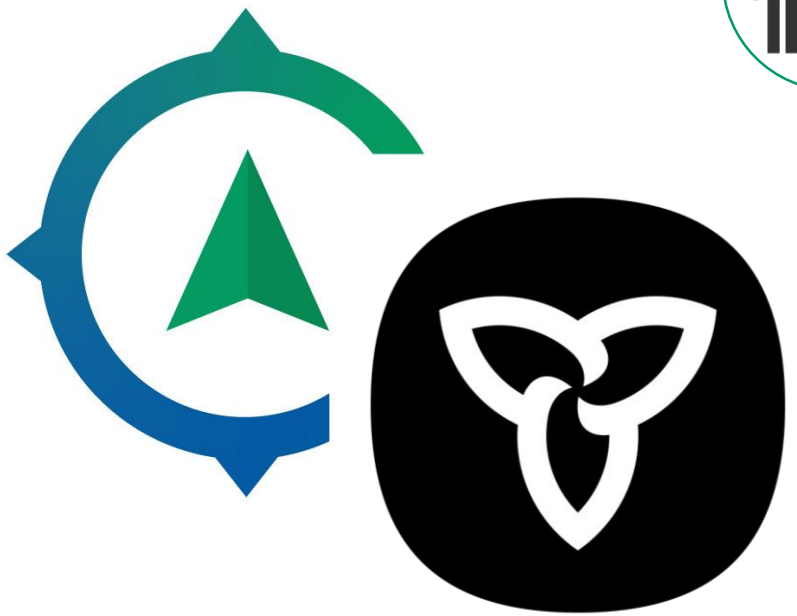
- Complete (and have learned from)12 projects
- Make an impact on almost 90,000 patients in North York
- Have at least 200 primary care providers actively participating in our partnership
- Be preparing for Year 2 projects, expansion of population and desired outcomes

Year 1 Patient Outcomes include:

- Delivering more coordinated and patient-centered care
- ↑ Access
- ↑ Services
- ↓ Wait Times
- ↓ Hallway Medicine

Supports and Enablers from MOH

Helene LaCroix, SE Health



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Freedom to Try

- Let us take risks, and work with us
- Earned autonomy, "learners permit"

1.Flex the rules so we can take down barriers

- Policy
- Governance
- Legislation

1.Facilitate Connections

- Horizontally (across OHTs, regions)
- Vertically (MOH, OH, Federally)

1.Funding that makes it easier to do the right thing

- Remove disincentives
- Creative ways to save/share/pool/invest
- Holistic accounting across: sectors, services, sources
- Seed funding to effectively implement and scale change

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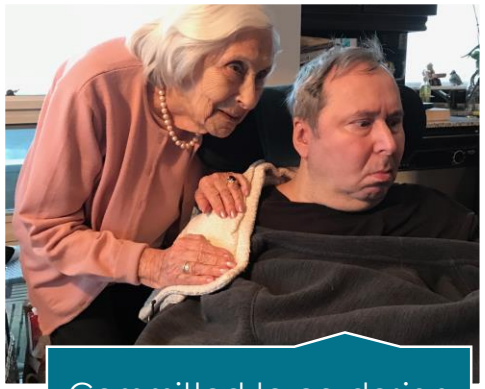
"Making care make sense"

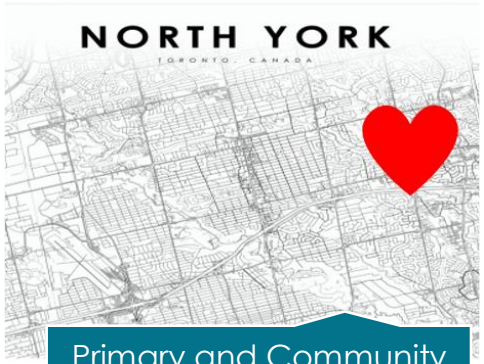
Stacey Daub, North York General Hospital

We get things done

Patients and Families are Embedded



Committed to co-design with our Community



Primary and Community Care at the Heart of North York

Implementation is Underway

We are not afraid

We want you to come with us

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