An Ontario Health Team for the East: East Toronto Health Partnership

Bellwoods Think Tank

March 21, 2019

MICHAEL GARRON HOSPITAL

WOODGREEN
Opportunity made here.

South Riverdale COMMUNITY HEALTH CENTRE

VHA Home HealthCare
Creating More Independence

PROVIDENCE Healthcare

Who We Serve in East Toronto

Population (2016)

275,385

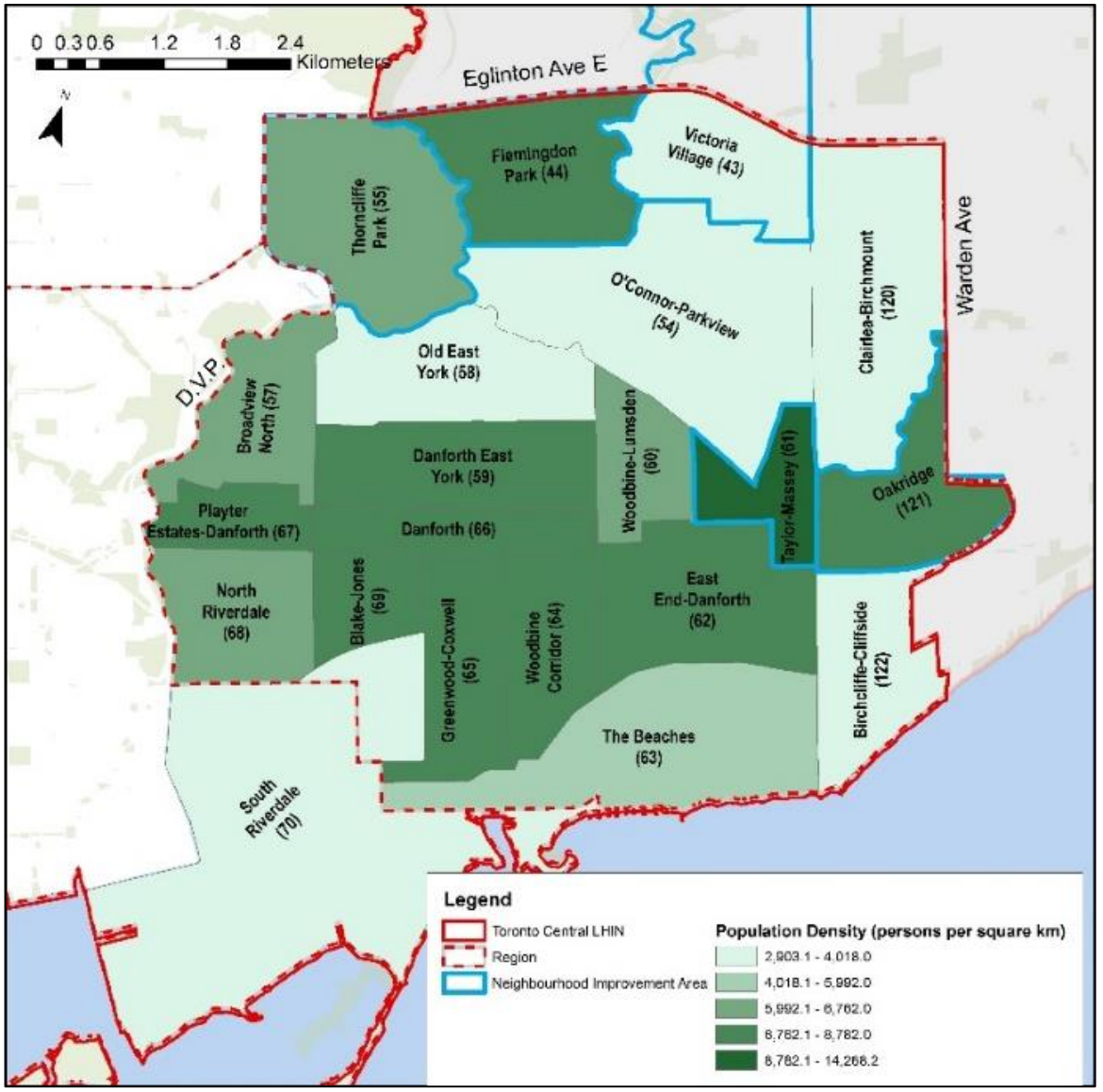
(**22.4%** of Toronto Central LHIN)
Population Density: 6,394.9 ppl / km^2

Child/Youth (age 0-19): 23.1%
Seniors (ages 65+): 13.7%

21 Diverse Neighbourhoods

5 Designated Neighbourhood Improvement Areas:

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



Who We Serve in East Toronto: Neighbourhood Ranges

Health Service Utilization

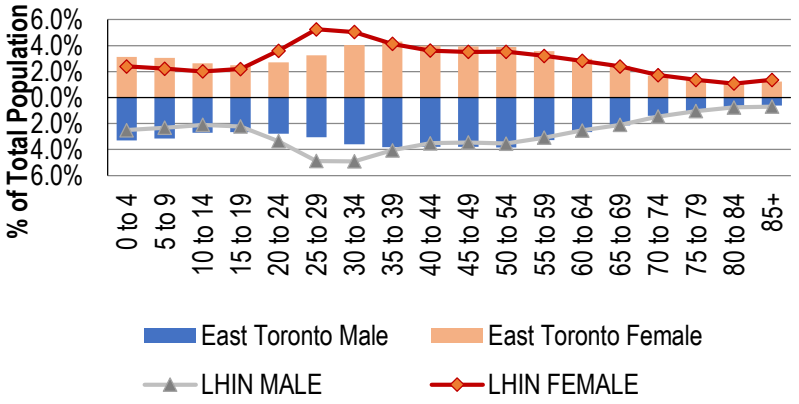
ED Visit Rates per 1,000 Pop'n (15/16 to 16/17)
265.9 – 445.0
Toronto Central LHIN: 322.1

Hospitalizations for Prenatal, Delivery and Postnatal Conditions per 1,000 Population (15/16 to 16/17)
31.0 – 64.6
Toronto Central LHIN: 36.6

Mental Health and/or Addiction-related Hospital Admissions per 1,000 Population (2015/16 to 2016/17)
2.7 – 20.5
Toronto Central LHIN: 6.6

Caregiver Distress (2017/18)
26.7% - 47.4%
Toronto Central LHIN: 34.2%

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



Neighbourhood Population Range
7,735 – 27,870

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

Sociodemographics

Low Income Measure, after-tax (2016)
9.3% – 45.5%
Toronto Central LHIN: 19.0%

Recent Immigrants (2011-2016)
1.6% – 18.6%
Toronto Central LHIN: 5.5%

% No Knowledge of English/French (2016)
0.2% – 8.1%
Toronto Central LHIN: 3.5%

Health Status

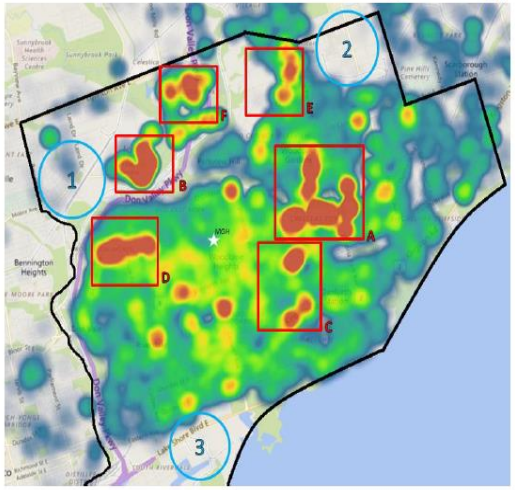
Children Vulnerable on 1+ EDI Domain (2015)
10.4% – 44.9%
Toronto Central LHIN: 26.9%

Birth Rate per 1,000 Population (2012/13 to 2014/15)
8.9 – 18.4
Toronto Central LHIN: 10.3

High Blood Pressure, Age 20+ (2016/17)
15.6% – 26.7%
Toronto Central LHIN: 19.3%

Diabetes, Age 20+ (2016/17)
5.6% – 16.9%
Toronto Central LHIN: 9.2%

ED Visits within MGH Catchment Area (Heat Map)



Low Density Visit Areas

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

High Density Visit Area

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

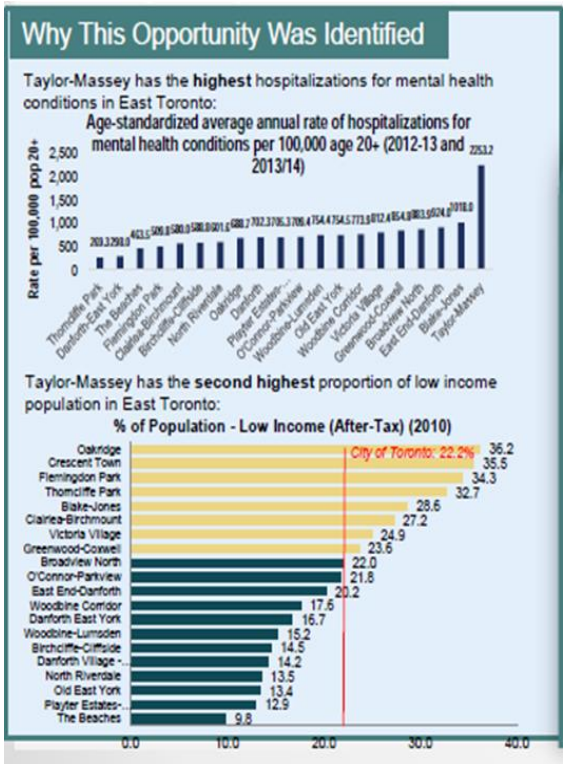
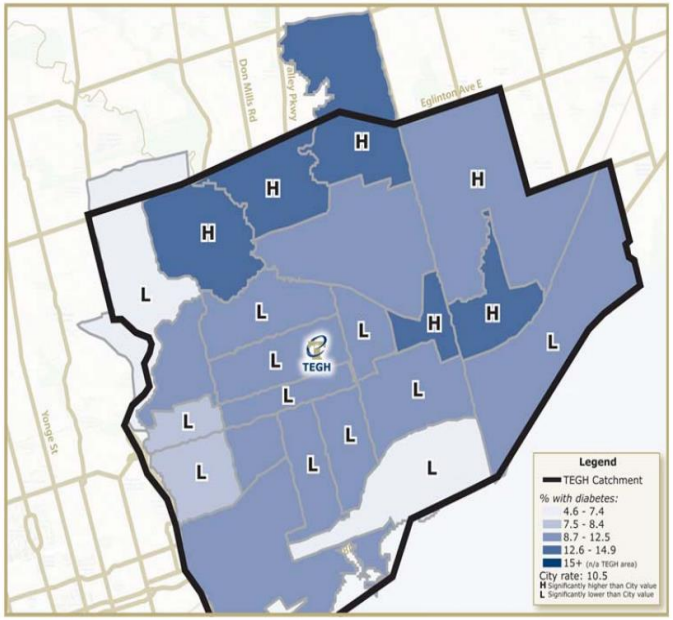


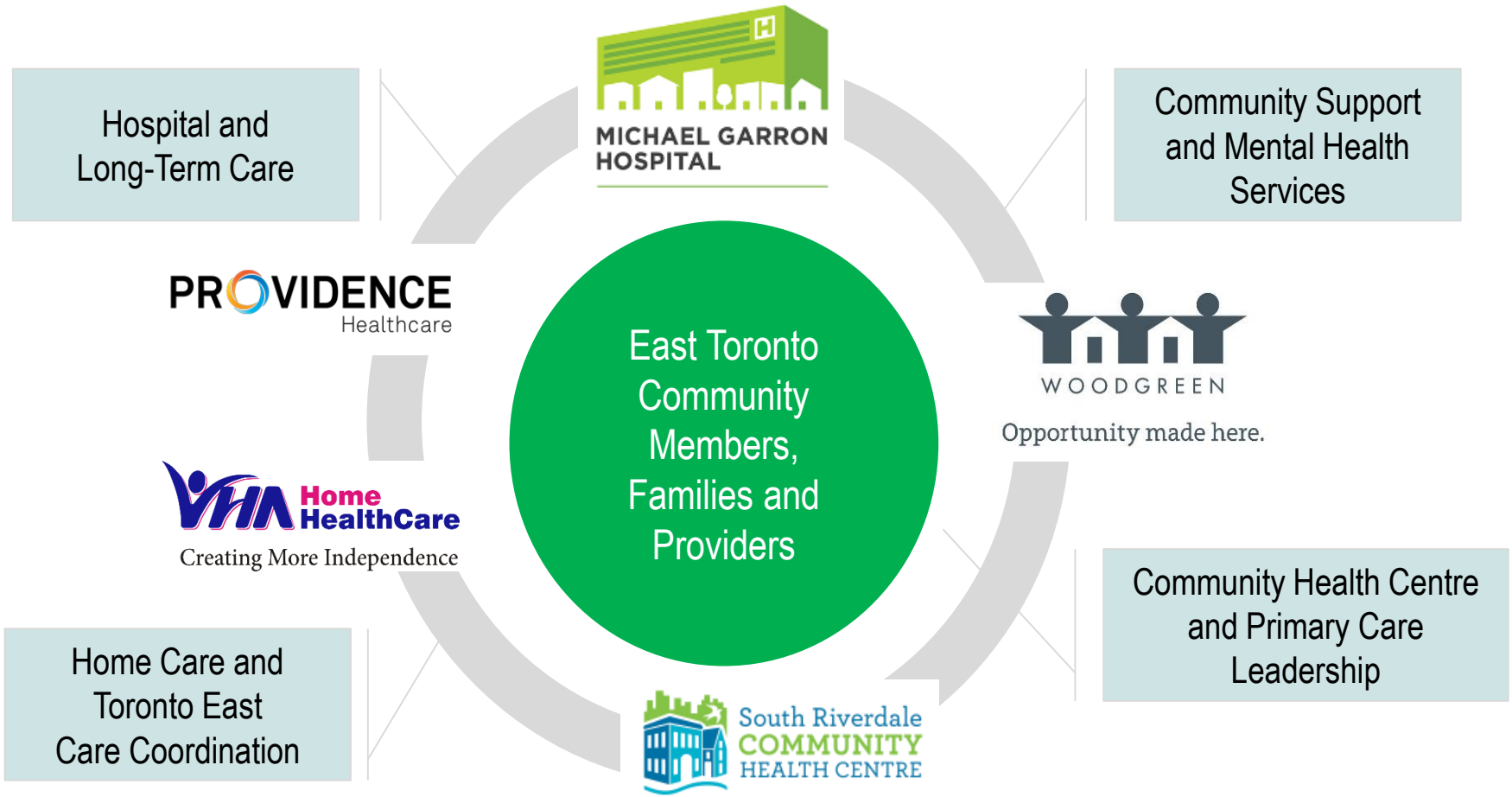
Figure 12: Diabetes Rates 20+ in the TEGH Catchment Area



East Toronto is prime for integration as an Ontario Health Team, building on long-standing collaborations and recent surge initiatives

The East Toronto Health Partnership: Creating Seamless Connected Care

Community-focused partners with long-standing collaboration, 40+ years serving East Toronto, and > 1.5 years' effort on service integration through a joint venture with shared governance and resources



The East Toronto Health Partnership delivers a comprehensive basket of health and social services, tailored to meet changing local needs

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

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

An East Toronto Ontario Health Team advances a shared vision for a 'System without Discharges', connected care built on early integrations

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

Chronic Disease Management and Home 2 Day

Integrated Mental Health and Addictions

Coordinated Home Care

Neighbourhood Care Teams

Community Support Services

Integrated Surge Response

Streamlined Access and Navigation, Enabled by Digital and Virtual Care

Coordinated Governance, Resource and Performance Management

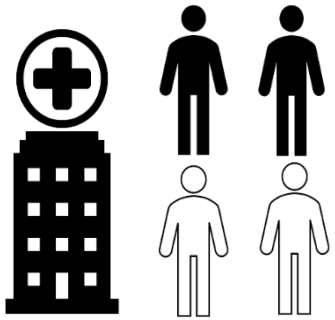
Integrated Surge Response: A collaborative investment of $1.5M into tailored health and social services for East Toronto

- In response to winter surge, East Toronto invested $1.5M into a range of hospital and community-based services to better meet the needs of our local community:

• **Expanded primary care after-hours clinics**	→	at Albany Clinic and in Thorncliffe Park
• **Community outreach to vulnerable populations**	→	including shelter and other settings
• **Neighbourhood-based flu vaccinations**	→	in several supportive housing areas
• **Support to congregate food security**	→	enabling continued food services
• **Enhanced weekend home-care services**	→	streamlining transitions home on weekends
• **Local reactivation services in the community**	→	with coordinated transition and home care
• **Expanded emergency department services**	→	reducing wait times and hallway health care
• **Initiation of Home 2 Day for COPD patients**	→	a new hospital at home model in East Toronto

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

Initial Hospital Admission



50% COPD Patients Eligible

Evidence-based Screening and Identification

Day 2 Transition

Integrated Acute Care at Home (> Day 2)

24 hr

O_2

- Inter-professional
- Multi-Provider
- Virtual Care Navigation
- Technology-Enabled Solutions

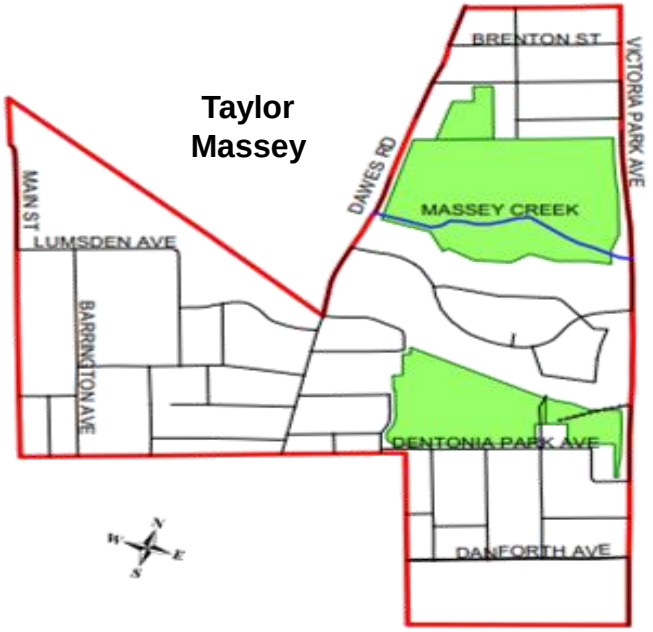
Program Discharge (5-7 days later)

Community Supports

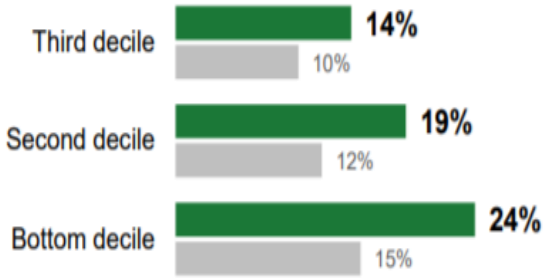
Family MD & Specialist F/U

Reduced Surge (2 beds/week)

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



Economic family income by decile group



33.1% of Seniors Living Alone*
Compared to City of Toronto rate of 26.7%

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

77.2% live in Apartments 5 stories or Above*
Compared to City of Toronto rate of 44.3%

11.5% Unemployment rate*
Compared to City of Toronto rate of 8.2%

47.4% Report Very Good or Excellent Mental Health ^
Compared to City of Toronto Rate of 73.4%

A Neighbourhood Care Team for Taylor Massey wraps tailored, integrated health and social care around community members

East Toronto Health Partnership Assets Leveraged

- Caregiver Support
- Employment
- Dementia
- Case Management
- Financial Empowerment
- Mental Health Nurses
- Settlement
- Counselling

Critical Success Factors

- Common Assessments
- Support to define Privacy and Circle of Care
- Cultural Specificity
- Connect with Grassroots Agencies

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

WOODGREEN
Opportunity made here.

1

Youth Cafe

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

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

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

east metro youth services

2

What's Up Walk-In Clinic

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

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

MICHAEL GARRON HOSPITAL

3

Multi-sector support

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

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

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

Ontario Health Teams support the East Toronto Health Partnership vision of integrated care; we are excited to accelerate our impact

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

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

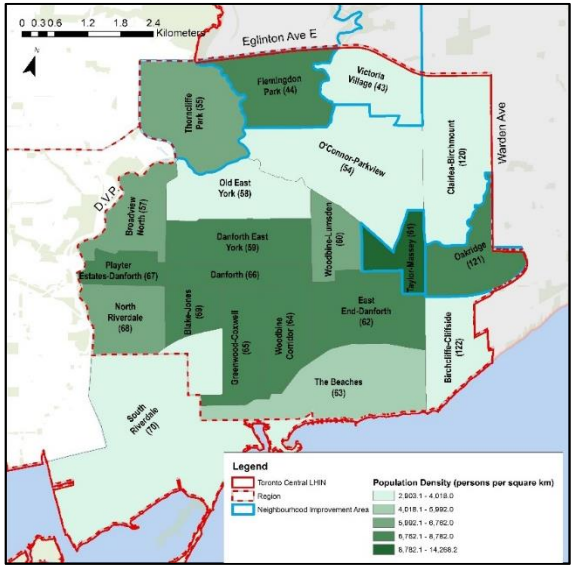
The East Toronto Health Partnership brings leadership from across hospital, home and community, supported by independent facilitation

• Carol Annett (CEO), **VHA Home HealthCare**	Home Care, CSS*	cannett@vha.ca
• Anne Babcock (CEO), **WoodGreen**	CSS, CMHA*	ababcock@woodgreen.org
• Jennifer Bowman (VP), **Providence**, Unity Health	Rehab, CCC	bowmanj@smh.ca
• Sarah Downey (CEO), **Michael Garron Hospital**	Hospital*	sarah.downey@tehn.ca
• Susan Fitzpatrick (CEO), **TC LHIN**	Funder*	susan.fitzpatrick@tc-lhins.on.ca
• Nicole Nitti, **Primary Care Lead**, East Toronto	Primary Care*	nicole.nitti@utoronto.ca
• Lynne Raskin (CEO), **South Riverdale CHC**	Primary Care*	lraskin@srchc.com
• Tess Romain (VP), **TC LHIN Home Care**	Home Care*	tess.romain@tc-lhins.on.ca
• Lee Fairclough (VP), **HQO**	Change Management Support	lee.fairclough@hqontario.ca
• Adalsteinn Brown (Dean), **University of Toronto**	Facilitator	adalsteinn.brown@utoronto.ca

Appendix:

About the East Toronto Health Partnership

Building on evidence, the East Toronto Health Partnership uses data on local health needs and health system utilization to target solutions (snapshot)



- East Toronto has a population of 275,385, ~22% of the TC LHIN
- There are 21 Diverse Neighbourhoods, with 5 Designated Neighbourhood Improvement Areas – needing a more focused effort on chronic disease:
  - Thorncliffe Park, Victoria Village, Oakridge, Flemingdon Park and Taylor-Massey
- Further, East Toronto has higher Mental Health and Addictions needs than the TC LHIN average: E.g. Taylor Massey has a 3X higher youth mental health utilization in the Emergency Department than TCLHIN

Examples of East Toronto Integration Efforts

- Solutions, East Toronto's Health Collaborative, in place since 2001, with over 20 voluntary initiatives (https://solutionshealthcollaborative.ca/)
- Recent surge efforts invested $1.5M in the community to improve access to primary care, health and social services in East Toronto
- Piloting integrated Mental Health and Addictions leadership

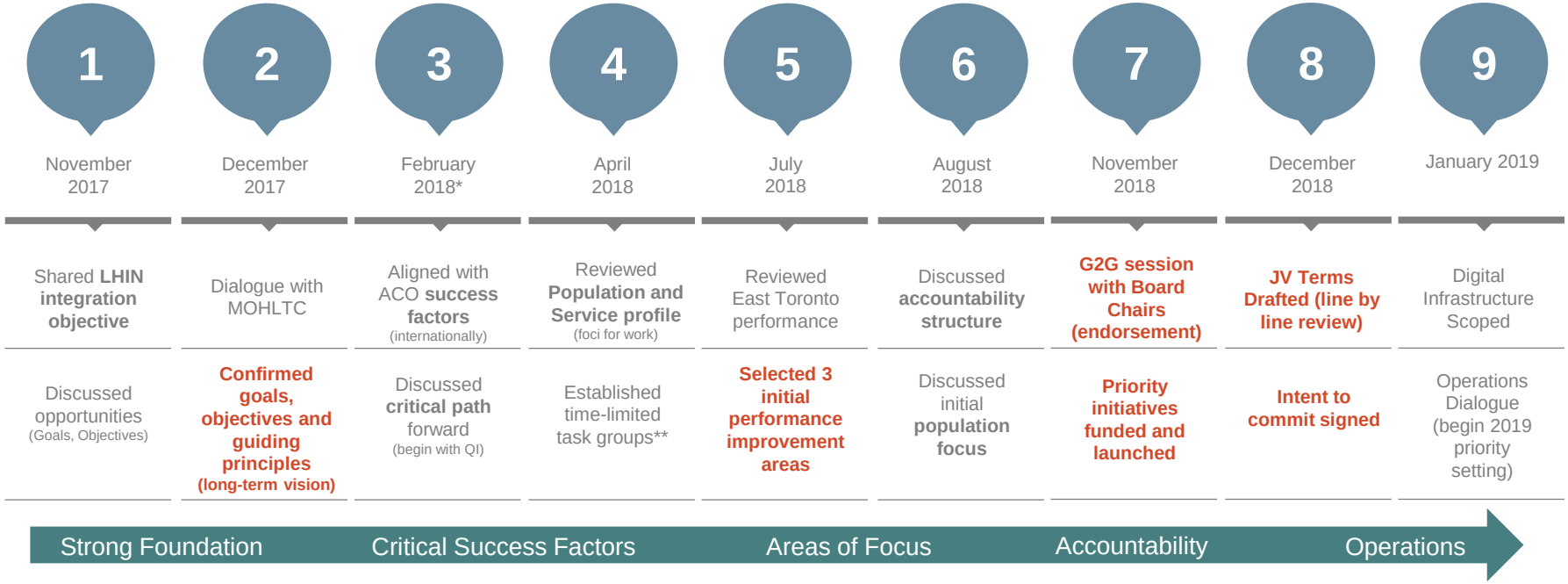
Through collaboration, the East Toronto Health Partnership established Guiding Principles to advance local care

- We are **guided by the needs of communities and the people we serve** (community over organization)
  - Build a system that responds to what we have heard
  - Respectfully engage residents / patients and communities
  - Respect diversity (guided by the citizen voice) and maximize equity (inform investments)
- Success will **require strong and engaged leadership** of the IHSDN
- Implementation will be underpinned by a willingness and **commitment to learning and continuous improving (rapid adaptation)**
  - This is an evolving / evolutionary process
  - Development is evidence-informed and will be supported with timely evaluation
- We will **capitalize and build on what has been accomplished to date**
  - Adopt values defined by the Local Collaborative (person-centred, transparent, cooperative, inclusive, leading change)
- Process will be **inclusive** and **transparent** both within the participant membership and with our partners in our communities
  - Will be implemented through a collaborative / participatory model and on a voluntary basis
  - This is a system approach
  - Committed to consistency in messaging and how we communicate

A set of Shared Goals build on the guiding principles, to focus integration efforts for an East Toronto Ontario Health Team

1. Everyone will know how to **access and navigate** health care in East Toronto
2. Every person will have **timely access to primary and inter-professional care** when needed
3. Communities will have access to ***Neighbourhood Care Teams*** with dedicated coordination for complex care needs
4. Every health care provider will be **connected as part of one system of care**, including primary care
4. Our leadership and governance model will reflect **shared accountability and collaboration** across primary care, community-based care, and hospital care
6. Performance measures will:
    - Reflect population **health outcomes** and equity
    - Reflect **patient and community experience**
    - Track **value**
    - Be **transparent and public**
7. Providers will be jointly committed to **continuous improvement** and **connecting with social services**
    - We will continuous **innovate**
    - One collaborative Quality Improvement Plan (cQIP) will be published
    - As a network, will actively engage partners to contribute to improving social determinants of health
8. Investment will be targeted to **meeting local need**

Launched in November 2017, the East Toronto Health Partnership achieved several key milestones, establishing the foundation for an Ontario Health Team



* March 2018 Facilitator Site Visits

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

10 February 2019: Review JV and discuss digital infrastructure. Drafting for both is underway.

11 March 2019: Plan and set priorities for 2019. Planning will begin following our January session.

12 April 2019: **Joint venture signed**. Funding and accountability agreements adjusted.

The journey from November 2017 prepares our senior teams and governance to lead this integration for East Toronto

- Our Founding Partners have signed an “intention to commit” to this initiative
- Governance-to-Governance hosted on November 22, 2018; Achieved unanimous Board Chair approval to pursue this initiative as a Joint Venture
- Michael Garron Hospital established as initial “fund holder” during transition period to future accountability arrangements (anticipated *Integrated Service Accountability Agreement*)
- Developed an integrated management structure, including:
  - Joint CEO leadership table
  - Integrated teams for shared initiatives such as Home 2 Day and Neighbourhood Care Teams

Although early, the East Toronto Health Partnership has a preliminary shared governance model, under active development

***A Future State (2020) inclusive of all East Toronto service capacity has been scoped with the support of the LHIN integration mandate**

As we scale, the Partnership is actively committed to leveraging our assets and deepening the continuum of service offerings

Enhancing Primary and Community-Based Care

Establish our offer to **235 primary care partners**: continue to expand SCOPE and SPIN

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

Meeting Diverse Needs

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

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

Developing Innovative Solutions with People

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

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

Example: Neighbourhood Care Teams, integrated care that is accountable to local needs in a high-density urban neighbourhood

Starting with core team functions, inclusive of:

1. Access to **regulated health, community supports, mental health and addictions**
2. **Care coordination** for complex clients; one care plan
3. **Primary Care** including Community Health Centres

Who will build on local teams with neighbourhood expertise, accountable for improving local outcomes, and be supported to:

- Include clients and caregivers as members of the care team
- Offer timely access (24/7)
- Test innovation and new partnerships
- Become neighbourhood experts
- Coordinate and organize care *based on local need*
- Connect to social services and local community supports (e.g. pharmacy, volunteer groups, churches, etc.)
- Connect with specialized and regional care

Creating positive impact in the community – local integrated health care that provides simple access to service, navigation / coordination if unable to self navigate, and streamlined communication of health care providers:

- Reduce inappropriate / avoidable ED and hospital use
- Eliminating duplication (roles, assessments, communication)
- Simple navigation
- Improve efficiency in service delivery
- Improving sustainability by increasingly connecting ‘upstream’

Supporting care integration, the Partnership has a structured approach to achieve digital connectivity through an 18-month roadmap

September 2019	March 2020	September 2020
Planning and focus on quick wins	**Build foundation for digital connectivity**	**Implement and iterate**
• Implement a single **secure messaging** solution • Ensure **access of patients to information** • Implement **virtual visits** (i.e., primary care eVisits)	• Establish data governance • Complete connectivity of Primary Care • Digitally enable the community sector	• Implement CRM-like solution to enable customer service • Centralize data and establish "command centre" model

Key Considerations:

- *Focus on a specific and defined scope and scalable successes: don't "boil the ocean"*
- *Demonstrate early success and build on established working partnerships; these will identify critical success factors for future projects*
- *Ensure alignment between patient workflow and clinicians*
- *Consider the extensibility of existing systems (e.g. Cerner, eCCP)*

Key Enablers for the East Toronto Health Partnership align with the Ontario Health Team vision, and will accelerate our momentum

- Achieving the vision for East Toronto – a System without Discharges – needs continued support from government and the new Ontario Health agency
- Key enablers to create a successful East Toronto Ontario Health Team include:

  - **Facilitation Support:** building on the leadership by the LHIN, supported by Steini Brown and HQO
  - **Changes to Funding:** pooled incremental funding and support in shifting key services to a single funding envelope across health and community services
  - **Integration of Home Care:** enabling the East Toronto Ontario Health Team to coordinate home care within the partnership, as a foundation to community services
  - **Digital Enablement**: creating seamless digital and virtual care platforms for the community and providers, building on local excellence in health technology advancement and integration across East Toronto
  - **Labour Harmonization:** Enabling the East Toronto community to fully benefit from an integrated Ontario Health Team, and front-line staff who serve them, requires wage harmonization and enabling changes to PSLRTA

Thank you from the East Toronto Health Partnership

MICHAEL GARRON HOSPITAL

WOODGREEN
Opportunity made here.

South Riverdale COMMUNITY HEALTH CENTRE

VHA Home HealthCare
Creating More Independence

PROVIDENCE Healthcare