East Toronto Health Partners

Operating Plan

Fiscal Year 2024-2025

Table of Contents

Introduction / Executive Summary 3

1.0 OHT Clinical Priorities 5

2.0 OHT Structural Requirements 21

3.0 OHT Digital Plan 30

4.0 OHT Community Engagement 34

5.0 OHT Risk Management 36

Introduction / Executive Summary

ETHP is proud to have been selected as one of the 12 initial OHTs to accelerate. The deliverables associated with OHT Acceleration comprise a significant component of our priorities for this fiscal year. In addition, we have several local initiatives for integration of care and improving population health that we will be advancing in collaboration with our partners and community members.

In FY23/24, ETHP developed a new shared purpose and belief statements through work led by our Community Advisory Council. Our new shared purpose and belief statements were launched in Q1 of FY24/25 to help guide our strategic and operational priorities and decisions as we progress through the next stages of our development.

ETHP Shared Purpose: “Building a healthier and more equitable East Toronto - enabling every person and neighbourhood to thrive”

As East Toronto organizations and community members working together, we believe in:

- **Collaboration** - Every organization and provider has a responsibility to help create an integrated system of care and work collaboratively in the best interests of the community;
- **Equity by Design** - By mobilizing our community and amplifying the voices of those not typically heard, we can co-design a more inclusive system that delivers high-quality care and equitable health outcomes for everyone;
- **Community-led change** - Our community inspires us to be bolder, push harder, overcome systemic barriers, and create the conditions to achieve and sustain positive change; and
- **Collective Impact** - The strength of our relationships is our greatest asset. Together, we are #OneEastToronto

In keeping with these statements, through FY24/25, ETHP will continue to:

- Advance a community co-leadership approach and co-design our accelerated OHT with our Community Advisory Council and community and caregiver councils. We recognize that our deep connection with our community is one of our greatest strengths.
- Expand our health equity work and implement our newly launched framework for anti-racism, equity, diversity and inclusion.
- Implement our Integrated Care Pathways to transform care for people with chronic conditions
- Support the development of our Primary Care Network and partner with them to address priorities for primary care, including HHR and capacity planning
- Play a leadership role in planning for changes to home care, including launching our leading project, integrating home care within our local models of care, and planning for future expansion of the role of OHTs in delivery of home care

- Work closely with our partners and community to evolve our local governance and advance the principles of trust, relationships, collaboration, transparency and accountability
- Advance local priorities for ETHP, with a particular focus on mental health, substance use, and youth wellness work given its importance within our community
- Mobilize ETHP partners to support a new Homelessness and Addiction Recovery Treatment (HART) Hub for East Toronto, following the provincial application process
- Launch a strategic planning process to identify our long-term collective goals for improving the health of the population of East Toronto.

1.0 OHT Clinical Priorities

Integrated Clinical Pathways (ICPs)	
Complete the following:	
Objective(s)	**Implement two or more Integrated Clinical Pathways (e.g., CHF, COPD, and/or LLP).**
Annual Goal/Target	Interim Goals: People enrolled into the program vs offered Long term goal: Readmission rates (25% reduction, 6-12 months post launch)
Key Partners Involved	Multiple ETHP partners have been engaged via engagement sessions and workshops. Working group members consist of representation from Community Members, CHC's, SPO's, Acute Care, Rehab, Primary Care, Mental Health and Substance Use, CSS and Social Services. For a full list of partners and names of organizations please see OH deliverable: Partner Engagement Plan
Milestones	ETHP will move forward to implement two Integrated Clinical Pathways: Congestive Heart Failure and COPD *PLANNING AND DISCOVERY:* • Developed plans and recruited clinical leads, patient representatives and working groups • Patient journey mapping, needs assessment, asset mapping, current state process mapping, community and partner engagement • Agreed upon design principles and desired impact, setting objectives • Measurement and Evaluation Framework • PRM readiness assessment *DESIGNING & BUILDING:* • Designed and prioritized ideal future state change initiatives to achieve objectives • Designed ideal future state process maps and clinical and administrative workflows • Engagements with partners including: • Feb 28th Partner Engagement Workshop (Current State Validation and Future State Design Principles) • May 14 Partner Engagement Workshop (Future State Validation and Implementation Planning) • Developed a phased implementation and change management plan

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<tr><td></td><td>
Developing a measurement and evaluation plan
BUILDING and IMPLEMENTING

Designed and built workflows and tools (10 processes from referral to care planning, 10 tools for assessments, action plans and self-management)
Preparing for implementation, building program materials, recruiting resources, onboarding providers, change management plan, communications, etc.
Pilot, monitor, and rapid cycle improvements (iterations)
Phase approach to for registration into program
Phase approach for referrals into program

TRANSITIONING TO OPERATIONS
Evaluation, enhancements, change management support, onboarding support, scale-out plan (phasing approach), operational plan
SUSTAINING
Improvement, Sustainability
</td></tr>
<tr><td>Description of Activities</td><td>
Multiple on-going engagements with partners including:

EasT-FPN (primary care network)
Specialists (Clinical leads)
MGH Leadership Priorities Council
MGH Endocrinology Rounds
Diabetes Education Programs
CHC Network
Engaged Partners
Homecare Service Providers
Provider Interviews
Asset Mapping Partner validation
Community Advisory Council
Patient interviews

</td></tr>
</table>

East Toronto
Health Partners

	• Focus groups • Taylor Massey Residents Council • Thorncliffe-Flemingdon Residents Council • Caregiver Advisory Group • All Partners Sessions Outcomes: • Patient Journey Maps • Needs Assessment and Problem Identification • Current State Process Maps • Co-Designed Impact Statements/Aims • Co-Designed Design Principles • Co-Designed Future State Objectives • Co-designed future state process maps • Clinical and administrative workflows • Co-designed tools for assessment, monitoring, reporting, self-management, scorecards and communications Other Activities: • Implementation phasing and planning • Priority setting (change initiatives to achieve the objectives) and budget allocation • Build out of future state protocols and processes • Resource planning • Change management and onboarding • Testing and iterations • Planning and prioritizing digital enablers • Measurement and Evaluation
Resources Required [OPTIONAL]	*Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)*

Chronic Disease Prevention and Management	
Complete the following:	
Objective(s)	**Design and planning, with potential to begin initial implementation*, of a locally identified model of care to support better chronic disease prevention and management in primary and community care settings, designed in collaboration with their Primary Care Network (PCN), enabling integrated clinical pathways and prevention and management of related conditions, and accounting for the needs of unattached and equity deserving populations.**
Annual Goal/Target	Alignment with ICP program and further supporting phasing into primary care. Using co-designed model for integrated care pathways for COPD and CHF, phasing into primary care setting by accepting referrals from primary care. Building on components of the ICP pathway to further expand on diagnoses and self-management. Building support for self-management within the current co-designed model for chronic disease care management. Interim Goals: People enrolled into the program vs offered Long term goal: Readmission rates (25% reduction, 6-12 months post launch)
Key Partners Involved	Multiple ETHP partners have been engaged via engagement sessions and workshops. Working group members consist of representation from Community Members, CHC's, SPO's, Acute Care, Rehab, Primary Care, Mental Health and Substance Use, CSS and Social Services. For a full list of partners and names of organizations please see OH deliverable: Partner Engagement Plan
Milestones	ETHP will move forward to implement two Integrated Clinical Pathways: Congestive Heart Failure and COPD *PLANNING AND DISCOVERY:* • Developed plans and recruited clinical leads, patient representatives and working groups • Patient journey mapping, needs assessment, asset mapping, current state process mapping, community and partner engagement

	• Agreed upon design principles and desired impact, setting objectives • Measurement and Evaluation Framework • PRM readiness assessment *DESIGNING & BUILDING:* • Designed and prioritized ideal future state change initiatives to achieve objectives • Designed ideal future state process maps and clinical and administrative workflows • Engagements with partners including: • Feb 28th Partner Engagement Workshop (Current State Validation and Future State Design Principles) • May 14 Partner Engagement Workshop (Future State Validation and Implementation Planning) • Developed a phased implementation and change management plan • Developing a measurement and evaluation plan *BUILDING and IMPLEMENTING* • Designed and built workflows and tools (10 processes from referral to care planning, 10 tools for assessments, action plans and self-management) • Preparing for implementation, building program materials, recruiting resources, onboarding providers, change management plan, communications, etc. • Pilot, monitor, and rapid cycle improvements (iterations) • Phase approach to for registration into program • Phase approach for referrals into program *TRANSITIONING TO OPERATIONS* • Evaluation, enhancements, change management support, onboarding support, scale-out plan, phased-out plan, operational plan *SUSTAINING* • Improvement, Sustainability
Description of Activities	*Multiple on-going engagements with partners including:*

	• EastFPN (primary care network) • Specialists (Clinical leads) • MGH Leadership Priorities Council • MGH Endocrinology Rounds • Diabetes Education Programs • CHC Network • Engaged Partners • Homecare Service Providers • Provider Interviews • Asset Mapping Partner validation • Community Advisory Council • Patient interviews • Focus groups • Taylor Massey Residents Council • Thorncliffe-Flemingdon Residents Council • Caregiver Advisory Group • All Partners Sessions Outcomes: • Patient Journey Maps • Needs Assessment and Problem Identification • Current State Process Maps • Co-Designed Impact Statements/Aims • Co-Designed Design Principles • Co-Designed Future State Objectives • Co-designed future state process maps • Clinical and administrative workflows • Co-designed tools for assessment, monitoring, reporting, self-management, scorecards and communications

<table>
<tr><td></td><td>Other Activities:
Implementation phasing and planning
Priority setting (change initiatives to achieve the objectives) and budget allocation
Build out of future state protocols and processes
Resource planning
Change management and onboarding
Testing and iterations
Planning and prioritizing digital enablers
Measurement and Evaluation</td></tr>
<tr><td>Resources Required [OPTIONAL]</td><td>Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)</td></tr>
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<table>
<tr><td colspan="2">Primary Care – Access and Attachment Services</td></tr>
<tr><td colspan="2">Complete the following:</td></tr>
<tr><td>Objective(s)</td><td>Develop and implement an access and attachment program that provides navigation supports and access to primary care clinical services for unattached patients (including for those with abnormal cancer screening result) and facilitates attachment to primary care providers and teams</td></tr>
<tr><td>Annual Goal/Target</td><td>Contribute to the Ontario Health Toronto Regional goal of attaching 55,000 unique clients to primary care
Through EasT-FPN-led access and attachment programs, system navigation models, and integrated pathways, attach residents that are unattached or poorly attached (access) to primary care and social services (access to primary/social care services) across the 21 distinct neighbourhoods, including the 5 East Toronto Neighbourhood Improvement Areas
Flemingdon Park
Oakridge</td></tr>
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East Toronto Health Partners

	○ Taylor Massey ○ Thorncliffe Park ○ Victoria Village
Key Partners Involved	• East Toronto family practices, including the network of CHCs EasT-FPN Primary Care Clinical & Executive Leadership Team and Administration Team (Director of Operations & Finance, EasT-FPN Project Management supports) • ETHP Leadership & Backbone Team • Michael Garron Hospital • Health Access Taylor Massey (HATM) core partners, including but not limited to: WoodGreen Community Services and South East Toronto Family Health Team • East Toronto community residents • Homecare partners • Flemindgon Health Centre (FHC) • Health Access Thorncliffe Park (HATP) • The Neighbourhood Organization (TNO) • MOH/OH/Ontario Health atHome Health Care Connect program
Milestones	The EasT-FPN, together with ETHP will: • Continue to advance the existing ETHP health access models – Health Access Taylor Massey and Health Access Thorncliffe Park. Our Health Access sites offer a one-stop access to integrated primary and community care services in equity-deserving neighbourhoods • Continue to explore sustainable funding models for Health Access Taylor Massey • Explore new health access models across East Toronto priority neighbourhoods, particularly, neighbourhoods with high primary care unattachment rates • Assess the current state of primary care capacity, starting in East Toronto neighbourhoods with significant health human resource gaps (i.e. high family practice retirement and retention rates and low primary care access and unattachment rates) • Advocate for and explore Interprofessional primary care (IPC) resourcing, to expand neighbourhood-based interprofessional family medicine practices and teams, intended to increase primary care provider's capacity to accept new patients

	• With PCN government investments, embed Holistic Intake Navigation Counsellors (HINCs) in family practices (part of primary care interdisciplinary teams), to support system navigation and case management, to enable primary care access and attachment • Test a model for integration of the provincial Health Care Connect program within our OHT and Primary Care Network

Description of Activities	*List all activities your OHT will undertake for FY 24/25 (including resources required).*
	
	• Embed the design of shared- care team models, to alleviate pressures from primary care providers and thus increases their capacity to accept new patients
	    ○ Design the implementation of shared-care team models, which embeds person-centred intake navigation of patients and families – targeting elderly patients, homebound patients, and patients with mental health conditions, who require complex social support
	    ○ Together with FHC, HATP, TNO and MGH, co-design and implement an ETHP primary care access point at MGH ED and HATP.
	    ○ Design the implementation of a Holistic Intake Navigation Counsellor (HINC), to be embedded in local family practices, located in the above priority neighbourhoods
	    ○ Leverage new and existing care pathways – including SCOPE, Intergrated Care Pathways (ICPs) patients with and at risk of chronic obstructive pulmonary disease, congestive heart failure, and patients requiring diabetes foot health, to enable the family practice HINCs to support case management, system navigation, to improve patient access and attachment to primary care
	    ○ Through primary care engagement efforts, obtain local East Toronto family practice characteristics and data – including information on family practice's capacity to accept new patients and their ability to access interprofessional primary care teams
	• Expand on community and primary care partnerships within HATM, to broaden residents within Taylor Massey, Oakridge and Crescent Town, access to comprehensive primary care
	• Partner with the MOH, OH and Ontario Health atHome to design and test a greater degree of integration for the Health Care Connect program within our OHT and Primary Care Network, aligned with the deliverables and plans for the i12 OHTs

	Note from OH - ***Please refer to the Operating Plan Guidance document to ensure that this section addresses all expectations outlined in the corresponding Final Operating Plan Guidance.***
Resources Required [OPTIONAL]	*Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)* • Support for testing changes to Health Care Connect with provincial resourcing • Sustainable funding for ETHP and EasT-FPN is required to fully advance the above activities and meet the above milestones • In-kind resources from the EasT-FPN Primary Care Executive Leadership Team and Administration Team • In-kind resources from HATM primary and community and social service partners

System Navigation	
Complete the following:	
Objective(s)	**Baseline Deliverables:** **1. Introduce continued system navigation improvements aligned to provincial guidance and measure impact on patient experience.** **2. Curate information about local services across Health811, OHT, and member organization websites and collect analytics about user behaviour across OHT digital assets**
Annual Goal/Target	Interim Goal: Integrate navigation into a minimum of 50% work projects/initiatives across the ETHP portfolios (as applicable). Long term goal: Navigation is an integral component across all ETHP portfolios (as applicable).
Key Partners Involved	**Toronto OHT Navigation Collaborative** (8 Toronto OHTs together with Francophone navigation partners, HCCSS, and Ontario Health) **Toronto Seniors Helpline** **Home & Community Care Support Services**

	Find Help 211 (vendor for Toronto Health & Social Services Directory) **Toronto Child & Family Network** (who have developed child & family content being added within Toronto Directory) **East Toronto Family Practice Network** (EasT-FPN) **Ontario Health / Health811** **For Digital Solution:** ETHP Collaborate – Michael Garron Hospital, WoodGreen and VHA Digital Support Model Development – MGH, VHA, WoodGreen, South Riverdale, Etc. Community Members Digital Guide Development – MGH, WoodGreen and community members Digital Strategy Development – various ETHP partners and members of the Digital Steering Committee Online Appointment Booking - EasT-FPN, other OHTs via community of practice, OAB vendors
Milestones	Engage local OHT teams, their communities, and Ontario Health in the decision around whether to extend the Toronto Health & Social Services Directory beyond the current contract end date (Feb 13, 2025) Contribute to system-wide navigation planning for Health 811, Coordinated MHA Access, Health Care Connect and evolution of Ontario Health at Home role in System Navigation (e.g. future plans for thehealthline.ca). Advocate for a digital navigation platform to access information on services and programs that includes real-time information on capacities and waitlists. Expand primary care access to unattached patients through multiple strategies, including expansion of Health Access model within East Toronto and enhanced inter-professional primary care “shared-care” team models. Implement our ETHP mental health & addictions cQIP, with purposeful use of a navigation resource role in the Michael Garron Hospital Emergency Department.
Description of Activities	**Monitor and sustain our Navigation assets** • Toronto Health and Social Services Directory user & visit data, most frequent search terms, and user feedback • Toronto Seniors Helpline and HCCSS phone navigation key stats and user feedback

	Toronto OHT Navigation Collaborative Continue to co-lead the Steering Committee for Navigation system improvements – a committee comprised of patient and caregiver representatives, the 8 Toronto OHTs, Francophone navigation partners, Ontario Health, and HCCSS. **Intake Navigation Specialists** (resource dependent) EasT-FPN will advance an interprofessional healthcare role, called Intake Navigation Specialists (INS). The INS position is unique in its emphasis on integrating trusted community members into multiple healthcare settings. INS will have hyper-local expertise of available ETHP community resources and services, as well as a deep connection to the communities they serve. The EasT-FPN plans to test this model by strategically placing INS within existing Health Access Models, and within East Toronto family practices clinics (e.g. solo MD clinics), to support the Integrated Care Pathways (ICPs) for CHF, COPD, diabetes and foot health. The INS will connect patients to existing health and social care interventions, including MGH's Virtual Ward, SeamlessMD, services and resources through the SCOPE program. **Navigation Resource in MGH Emergency Department** Implement MHA cQIP - Improve connections to community services in the Michael Garron Hospital ED through use of a purposeful navigation resource. Consider better use of "waiting time" during a patient's ED journey and integrating service provision of partners into the navigation resource role.
Resources Required **[OPTIONAL]**	*Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)*

Cancer Screening	
Complete the following:	
Objective(s)	**Increase participation rates for breast, colorectal, and cervical screening.**

<table>
<tr><td>Annual Goal/Target</td><td>Achieve cancer screening participation rates as outlined in 2024-25 collaborative Quality Improvement Plan: 0.1% increase in eligible patients up-to-date with Papanicolaou tests, mammograms, and colorectal screening</td></tr>
<tr><td>Key Partners Involved</td><td>EasT-FPN including health access models, East Toronto CHC network, Michael Garron Hospital</td></tr>
<tr><td>Milestones</td><td>Implementation of Poppy Bot to identify, stratify and reach out to patients due for cancer screening in primary care Electronic Medical Records.
Training of community health ambassadors (CHA) for outreach to priority communities with lower cancer screening rates, working with CHC network to understand health equity data
Further use and deployment of CHA Cancer Screening blueprint (handbook) designed with behaviour science to guide conversations with community using motivational interviewing and conversational receptiveness.</td></tr>
<tr><td>Description of Activities</td><td>1. Sustaining Poppy Implementation (bot to identify, stratify and reach out to patients due for cancer screening in primary care Electronic Medical Records).
Continue to work with sites with Poppy implementation. Monitor cancer screening rates at participating clinics for colorectal, cervical and breast cancer screening. Implement enhancements as needed. Working with site clinical and admin leads to monitor poppy runs.
2. Community Health Ambassador (CHA)-led engagement in priority neighbourhoods (pending funding).
Usage of CHAs to build capacity, address barriers and provide education and access points for community members to learn more and obtain screening. Training and Educational sessions for CHAs. Empower community ambassadors to build trust with the community to increase awareness and support to obtain screening.
Funding support is required to continue to advance preventative care. Elimination of preventative care bonus for Primary Care poses an issue. Low barrier access to providers to conduct cervical cancer screening is a challenge as there is no capacity or incentives.</td></tr>
<tr><td>Resources Required
[OPTIONAL]</td><td>Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)</td></tr>
</table>

Local Priority #1 Mental Health and Substance Use	
Complete the following:	
Objective	Increase connection and access to outpatient and community-based mental health and substance use services
Annual Goal/Target	cQIP indicator: 1st presentation to ED for Mental Health & Substance Use – decrease 0.01
Key Partners Involved	Michael Garron Hospital, WoodGreen Community Services, South Riverdale Community Health Centre, St. Michael's Homes, Strides Toronto
Milestones	• Develop and implement a mental health outpatient urgent care clinic at Michael Garron Hospital. • Improve connections to community services in the Michael Garron Hospital emergency department through the use of a purposeful navigation resource. • Pursue integrated care model and funding for substance use. • Initiate a proposal and working group for a Taylor-Massey youth wellness hub. • Develop and implement a youth outreach team. • Submit a proposal for a new HART Hub site aligned with provincial priorities for improving access to treatment and support for people facing issues of substance use
Description of Activities	1. Urgent care clinic: community engagement and consultation via MGH and ETHP network; project development and implementation led by MGH; evaluation and ongoing quality improvement. 2. Improve connections to community services: explore specific initiatives/interventions. 3. Integrated care for substance use: pursue the application for substance use disorder integrated care pathway (SUD ICP) and Homelessness and Addiction Recovery Treatment (HART Hub); explore additional funding for Oakridge Health and Harm Reduction Hub. 4. Taylor-Massey YWH: bring together local service providers interested in the YWH project; prepare a proposal/business case for the YWH 5. Youth Outreach Team: community engagement and consultation via the WG youth team; design service offerings, referral pathways, and evaluations based on identified needs; implementation, evaluation and ongoing quality improvement Collaboration and Integration: • Engage in quality improvement capacity building workshops and activities with CQuIPS.

	• Collective advocacy on MH&SU system concerns and issues. • Integrate child and youth mental health lead agency plan into ETHP planning and activity for youth mental health. • Expand portfolio membership to include more local service providers.
Resources Required	• Slaight funding for Youth Outreach Team • In pursuit of YWHO funding for Taylor-Massey YWH • In pursuit of SUD ICP funding, HART Hub funding and Toronto Urban Health funding for substance use initiatives • In-kind support for the rest. There is currently no dedicated funding for OHT-level MH&SU initiatives.

Local Priority #2 Transitions in Care cQIP	
Complete the following:	
Objective	Build a strong network of care providers to bring individuals home from hospital and keep seniors living well, with supports, in the community
Annual Goal/Target	-cQIP indicator: Alternate Level of Care for ETHP attributed population – decrease % ALC by 0.1 -Achieve key performance metrics of MGH2Home Program (240 clients served within the fiscal year)
Key Partners Involved	Michael Garron Hospital, WoodGreen, VHA Home Healthcare, Spectrum Health Care, Regional Geriatric Program of Toronto, Registered Nurses Association of Ontario, Providence Healthcare, South Riverdale Community Health Centre
Milestones	**March 2024:** Submit the ETHP Collaborative Quality Improvement Plan **April 2024:** Approve the work plan for 2024-25, through the Integrated Home Care and Transitions Portfolio Steering Committee **May 2024:** Disseminate findings and recommendations from Year 1 evaluation of MGH2Home Program **June 2024:** Official designation of ETHP as a Best Practice Spotlight OHT at RNAO Annual General Meeting **June 2024:** Train-the-trainer session hosted by Regional Geriatric Program of Toronto for Senior friendly care micro-learning sessions; 4 ETHP Trainers participate and will lead Delirium education sessions with provider groups and community **Summer 2024:** Launch RNAO Advanced Clinical Practice Fellowship studying Transitions in Care & Services through MGH2Home Program

	Fall 2024: Launch new Best Practice Guidelines implementation for ETHP: Pressure Injuries & Prevention and Management of Diabetic Foot Ulcers
Description of Activities	• Support people's Transitional Care needs from hospital to home (optimizing operations of MGH2Home Program and linking patients to resources when unattached to primary care) • Increase capacity of front-line providers through senior friendly care at the foundation training • Co-design and collaborate with patients and caregivers, and service providers, implementing the RNAO ***Transitions in Care and Services*** Best Practice Guidelines. • Improve integrated care planning through integration of PCCRTs within Integrated Care Pathways, MGH2Home and Home Care Leading Project.
Resources Required	*Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)*

Please copy & paste additional tables as needed for local priorities.

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2.0 OHT Structural Requirements

Patient, Family and Caregiver Involvement	
Complete the following:	
Objective(s)	**Implement an advisory council comprised of patients, families and caregivers within the OHT local community.**
Annual Goal/Target	Involve ETHP's Community Advisory Network members in all OHT initiatives and projects
Key Partners Involved	WoodGreen, TNO, MGH, SRCHC ETHP has established 6 Advisory Councils connected in ETHP's advisory network. 1. Community Advisory Council (CAC) 2. Caregiver Advisory Group (CAG) 3. Taylor Massey Residents Wellness Council (TMRWC) 4. Thorncliffe Park Residents Wellness Council 5. Youth Advisory Council (WoodGreen) 6. Youth Advisory Council (TNO) Pending – Substance Use & Mental Health Advisory Group
Milestones	Involve ETHP's Advisory Network members in: - Home Care Modernization project (TMRWC) - Home Care Readiness Assessment (CAC & CAG) - Governance model - Integrated Care Pathways
Description of Activities	1. Co-chairs from the CAC, and TMRWC attend the Leadership team mtgs. A patient/ caregiver advisor has stepped into the role of OHT Community Co-lead in a triad model of leadership with OHT Admin and Clinical Leads. This ensures bi-directional communication between the ETHP Advisory network (60 advisors) and the Leadership team.

East Toronto Health Partners

	2. The Community Advisory Council has developed a work plan that is aligned with the OHT's priorities. (Topics scheduled for 2024/25 mtgs include Primary Care networks, Home Care, ICPs, Governance) 3. ETHP advisory network members participate in quarterly ETHP planning sessions with partner organizations. 4. Ad-hoc consultations with ETHP Advisory networks as needed based on ETHP's progress towards designation.
Resources Required [OPTIONAL]	*Engagement budget for the advisors' honorariums and additional funds for the implementation of the CAC work plan (incl. Patient/caregiver advisor training, engagement events etc.)* *Leadership team and backbone team support*

Home Care Readiness	
Complete the following:	
Objective(s)	**Complete a Home Care Readiness and Delivery Plan aligned with guidance when available**
Annual Goal/Target	-Achieve all elements of upcoming Home Care readiness and delivery plan by March 31 2025, including confirmation of the governance approached (lead Health Service Provider) for future home care delivery within East Toronto Health Partners. -Launch Integrated Neighbourhood Home Care Program (Leading Project) in ETHP
Key Partners Involved	-East Toronto community members, patients / caregivers / family members -ETHP Leadership Team -East Toronto Family Practice Network -Michael Garron Hospital -Providence Health Care (Unity Health Toronto) -Ontario Health atHome -East Toronto Home Care Service Provider Organizations (e.g. VHA, Spectrum, Closing The Gap & larger SPO Network) -East Toronto Community Support organizations (e.g. TNO, WoodGreen, The Neighbourhood Group) Health Access Thorncliffe Park & Health Access Taylor Massey Community Health Centres (Flemingdon Health Centre, Access Alliance, South Riverdale CHC, East End CHC)
Milestones	• Nov 2023-Sept 2024: Contributed to Procurement & Contracting of SPOs for ETHP Leading Project

	• April/May 2024: Home Care 101 (3 sessions) & Change Management Sessions (4 sessions) held with frontline providers in 2 neighbourhoods • July 2024: Launched Home Care Steering Committee for East Toronto • July-Oct 2024: Held 4 community events for community engagement around new Integrated Neighbourhood Home Care Program • Sept 2024: ETHP/MGH hosts initial Community of Practice for Hospital 2Home Programs in Toronto Region • Sept 2024: Two new Primary Care Leads hired to support integrated neighbourhood home care teams. • Oct 2024: Signing of all CHRIS agreements for local CHRIS tenant (at MGH) • Nov 2024: Launch of Leading Project (Integrated Neighbourhood Home Care Program) • Dec 2024: Leading Project oversight committees confirmed – performance & quality, relationship committee etc.; Overall OHT Governance Recommendations presented by ETHP Governance Planning Committee • Ongoing since 2019: Quarterly Home Care SPO network meetings for East Toronto SPOs • Ongoing since 2023: Weekly touch base with Ontario Health atHome (OH atHome Director & ETHP, MGH) • March 2025: Complete Home Care Readiness and Delivery Plan
Description of Activities	ETHP has been developing and fine tuning our Home Care Leading Project vision and plans since fall of 2021 and is well positioned to support additional home care delivery through OHTs. Our Home Care Leading Project (to launch in Nov 2024) will generate additional experience and learning within our OHT (and within our Lead Health Service Provider: Michael Garron Hospital) around home care contracts and oversight, quality & performance, use of the CHRIS information system, and enablers to effective integrated team models with strong connection to primary care, within the 2 neighbourhoods. ETHP will continue to deliver its MGH2Home Program, which has undergone important changes following program evaluation and operational optimization in spring of 2024. ETHP will formally begin a planning exercise with partners to plan for additional home care populations to be included within integrated team-based care, for 2025-26

Resources Required **[OPTIONAL]**	*Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)*

Primary Care Networks (PCNs)	
Complete the following:	
Objective(s)	**1. Demonstrate that the OHT's PCN meets provincial requirements in alignment with PCN Guidance** **2. Provide digital/clinical supports to PCN members (e.g., SCOPE, Best Care, other supports)**
Annual Goal/Target	Fiscal Year 2025 EasT-FPN Goals: **1) Through an EasT-FPN Primary Care & HHR Recruitment & Retention Resource (enabled by PCN-Allocated Government Investments):** • Assess the current state of comprehensive family practice in East Toronto, including but not limited to: primary care provider's years of practice, retirement and/or retention plans, patient roster size, practice model type, practice enablers, to support accepting new patients, use of digital tools/assets. • Develop an EasT-FPN/ETHP strategy to attract, recruit & transition primary care into practice 2) **Expand Family Practices' Access to Community & Hospital Resources (enabled by PCN -Allocated Government Investments):** • Expand on existing and create new pathways for simplifying primary care provider's access to to speciality care, community care, homecare and social services – using SCOPE, Hypercare, eReferral and eConsult. • Develop targeted strategies that address barriers to primary care provider's access to speciality care, community care, homecare and social services **3) Expand Team-Based Primary Care:** • Seek IPCT Expansion funding, to expand primary care provider's access to local IHPs **4) Increase Primary Care Access & Attachment (enabled by PCN-Allocated Government Investments):** • Contribute to the Ontario Health Toronto Regional goal of attaching 55,000 unique clients to primary care

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<tr><td>Key Partners Involved</td><td>

East Toronto family practices, including the network of CHCs
EasT-FPN Primary Care Leadership & Governance Structure, including:

EasT-FPN Primary Care Clinical Leadership Team and Administration Team (Director of Operations & Finance, EasT-FPN Project Management supports);
EasT-FPN Board of Directors
EasT-FPN Executive & Governance Committee

ETHP Leadership & Backbone Team
Michael Garron Hospital
HATM core partners, including but not limited to: WoodGreen Community Services and South East Toronto Family Health Team
East Toronto community residents
Homecare partners
Flemingdon Health Centre
The Neighbourhood Organization
Health Access Thorncliffe Park

</td></tr>
<tr><td>Milestones</td><td>
The following milestones align with the vision, objectives, & common set of functions for PCNs in OHTs, as outlined in the OH PCN Guidance Document & PCN Readiness Assessment. The EasT-FPN, together with the ETHP will prioritize activities to meet the following milestones.

Connects Primary Care within the OHT

Implement a new Client Relationship Management (CRM) tool, to (1) Enhance the data the EasT-FPN collects from and about EasT-FPN members (2) The process of how the EasT-FPN collects data (3) How the EasT-FPN collates and analyzes local-level family practice data (4) How the EasT-FPN uses data to inform planning, decision-making, targeted engagement and advocacy for primary care.

Primary Care Voice in OHT Decision-Making

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	• Continue to have Primary Care Executive Leadership co-design decisions, for the Structural OHT Acceleration Deliverables (e.g. creation of a non-for-profit OHT corporation) and the Patient-Facing Deliverables (e.g. development of the Integrated Care Pathways). • Seek PCN-allocated government investments to recruit for the EasT-FPN Chief Executive Medical Officer position • Expand on primary care representation across ETHP committees, working groups, and advisory tables • Continue to align OHT priorities with local (East Toronto) local primary care priorities • Expand on the EasT-FPN skills-based Board of Directors, including broadening board representation from EasT-FPN members and non-clinicians 3. **Supports Primary Care Members to Advance OHT Clinical Change Management and Population Health Management Approaches that relate to Primary Care** • EasT-FPN to continue to mobilize data from multiple sources [(local family practice data via in-person clinic visits and surveys; cross-sectional survey data from a study led by U of T DFCM)], to better understand the attributed populations that family practices care for 4. **Facilitates Access to Clinical Supports & Improvements for Primary Care** • Continue to assess and collect data on the various clinical supports currently used and needed by East Toronto family practices –including, but not limited to use of OCEAN e-Referral, types of EMR platforms, SCOPE, OAB website for family practice clinics and AI solutions • Continue to support the implementation of digital solutions, through a stepwise approach and work with practices to lessen the intensity of change management associated with the integration of digital solutions • Continue to harmonize the various digital solutions used by family practices 5. **Supports Local Primary Care HHR Planning within the OHT** • Continue to broaden the EasT-FPN's access data on the state of primary care HHR capacity in East Toronto, to define the needs for team-based care within the ETHP – seek data from external partners and via local primary care engagement efforts

	• Leverage existing partners' (e.g. MGH, Middlesex London OHT) best practices and processes for successful recruitment and retention of healthcare providers • Co-design team-based care models (e.g. Intake Navigation Specialists, Physician Extenders – Physician Assistants, Primary Care NPs, Mental Health Nurses & Counsellors) that can alleviate primary care pressures and unlock primary care capacity. • Work with ETHP to embed these models into existing and new patient care pathways
Description of Activities	The EasT-FPN, together with the ETHP will lead the following activities, enabled by PCN-Allocated Government Investments: • Implement a new Client Relationship Management (CRM) tool, to (1) Enhance the data the EasT-FPN collects from and about EasT-FPN members (2) The process of how the EasT-FPN collects data (3) How the EasT-FPN collates and analyzes local-level family practice data (4) How the EasT-FPN uses data to inform planning, decision-making, targeted engagement and advocacy for primary care. • Broaden membership recruitment and engagement efforts, using various communication and engagement mechanisms – including in-person clinic engagement meetings, virtual engagement meetings and surveys • Broaden efforts to measure/track recruitment and engagement activities with family practices – leveraging the EasT-FPN CRM • Collect data on local family practice characteristics, including primary care's access to interprofessional primary care teams, years of practice, practice challenges and supports needed • Via Primary Care Executive Leaders, continue to ensure the local and provincial primary care priorities and strategic goals, are embedded in the OHT leadership and governance tables (e.g. ETHP Leadership Table), where decisions are being made. • Continue to collaborate with the ETHP to recruit, onboard and reflect on the performance of shared EasT-FPN/ETHP roles • Prioritize efforts to sustain existing models (HATM), that support increasing access and attachment to comprehensive primary care, with a focus on equity-deserving populations (e.g. Indigenous, Black, Francophone etc.) and neighbourhoods (Taylor Massey, Cresent Town, Oakridge) • Co-design (via the EasT-FPN Executive & Clinical Leadership & local family practices) the ETHP Integrative Care Pathways for COPD, CHF and Diabetes Foot Health – embed "upstream" interventions,

East Toronto
Health Partners

	processes and resources that support the primary care case/care management of patients with and/or at risk of COPD, CHF and diabetes lower limb preservation • Leverage existing partners' (e.g. MGH, Middlesex London OHT) best practices and processes for successful recruitment and retention of healthcare providers • Allocate government-invested PCN resources, for East Toronto Primary Care HHR assessment, monitoring, attraction, recruitment and transition in practice activities • Work with the province to test a greater integration of the Health Care Connect program within in our local PCN and OHT • With PCN-allocated government investments, co-design team-based care models (e.g. HINCs, Physician Extenders – Physician Assistants, Primary Care NPs, Mental Health Nurses & Counsellors), that can alleviate primary care pressures and unlock primary care capacity.
Resources Required **[OPTIONAL]**	*Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)* • Sustainable funding for ETHP and EasT-FPN is required to fully advance the above activities and meet the above milestones • In-kind resources from the EasT-FPN Primary Care Executive Leadership Team and Administration Team; EasT-FPN Governance Structures (Board of Directors, Executive & Governance Committees) • In-kind resources from HATM primary and community and social service partners • Resources to test and evaluate changes to the Health Care Connect program at a local level

OHT Membership	
Complete the following:	
Objective	**1. Ensure OHT membership and decision-making requirements (including Patient, Family and Caregiver representation) outlined in Ontario Health Teams: The Path Forward are met, providing support and resources to facilitate these partnerships and activities.** **2. Demonstrate targeted outreach efforts to expand OHT membership to include additional sectors (e.g., optional membership groups described in *Ontario Health Teams: The Path Forward*), aligned maturity.**

Annual Goal/Target	Refreshed ETHP Governance structures in place by March 31, 2025, building on and growing from the initial Joint Venture Agreement for ETHP (dated 2019) and co-designed with partners and community members. Strengthen system-level governance and collaboration at both at an OHT-level (macro-level governance) and project/program level (micro-level governance) across partners and community members.
Key Partners Involved	A call for volunteer participation in a Governance Planning Committee was shared with the entire ETHP membership, including community advisors. Leaders and team members from partner organizations and community advisors across East Toronto (28 committee members across the OHT), have committed to co-designing an ETHP governance framework, across working sessions that will take place over 4-6 months.
Milestones	• Establish a Governance Planning Committee (including leaders and community members with different levels of experience with governance) to advise on the structures and processes needed to achieve collective impact and work collaboratively to achieve the vision and purpose of the ETHP. • Expand OHT membership to include essential sectors to plan for population health across East Toronto, including city planning and redevelopment, and public health.
Description of Activities	• Schedule Governance Planning Committee working sessions to co-design a governance framework grounded in the principles of trust and transparent and inclusive decision making. • Meet individually with leaders across the OHT, to understand their individual organization's goals and their vision for our collective goals as an OHT. • Organize a Neighborhood Care Planning Session for partners and community members from equity-focused neighborhoods to share ideas for what structures, processes, and partnerships are needed to meet shared goals. • Connect with partners from additional sectors such as city planning (e.g transit, housing, etc.) to ensure that involved partners are representative of the sectors that will have impact on the delivery of health and social care within East Toronto. • Work closely with the Resident Councils/Community Advisors and front-line team members, to plan for expansion of integrated service models across the OHT. • Strengthen community engagement to build a sustainable framework for partnership with community members, as OHT membership expands.

Resources Required [OPTIONAL]	*Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)* OHT backbone supports have increased to support integration within the neighborhood access models and across the system, to build a foundation for partnerships across the OHT.

3.0 OHT Digital Plan

Digital Plan	
Complete the following:	
Objective(s)	**Develop and execute an ETHP OHT Digital Plan**
Annual Goal/Target	The following are the ETHP Digital Team's main goals for this fiscal year which are centered around maturing our digital network to strengthen our operating support model and establishing a path for how our digital architecture must evolve to support our programs: • Complete the pilot of ETHP Collaborate with PCCRT and East-Can • Develop a digital architecture maturity planning document • Establish vendor partnership opportunities for the advancement of ETHP's digital maturity
Key Partners Involved	*Identify OHT partners who will be involved in delivering each priority and initiate engagement.*
Milestones	The following milestones are based on priorities that are captured in ETHP Digital Strategic Plan (2023-2025) and are tied to current limited funding available for this work to be executed: 1. Completion of ETHP Collaborate Care Planning Tool pilot– end of 24/25 2. Draft Digital Support Model – end of 24/25 3. Draft a Community Members Digital Guide to Navigating ETHP Tools – end of 24/25 4. OHT M365 Backbone Architecture Planning – end of 24/25 5. ICP and Home Care Project IT Supports Planning 6. Online Appointment Booking – end of FY 24/25

	7. AI Scribe – assist PCPs with onboarding and deployment of AI Scribe tools to help reduce administrative burden, and explore opportunities to use aggregate data to inform primary care supports and population health activities - end of FY 24/25
Description of Activities	1. **ETHP Collaborate Pilot Completion**–Execute the pilot with participation from PCCRT and East-Can. An evaluation of the tool will be underway and an assessment of how to scale the solution to other programs will be done. 2. **Digital Support Model Development**– create an OHT resourcing plan to support the shared digital resources and applications commonly used across the partner organization. Resources: leverage existing 2 project resources and various technical resources across ETHP partner's IT teams to support assessment and planning 3. **Community Members Digital Guide Development**– draft a guidance document for community members to understand recommended best practices around cybersecurity and support for navigation the collaboration tools standard to the OHT. This will require 2 project resources and various community advisors/ambassadors to support 4. **OHT M365 Backbone Architecture Planning** – Assess and plan how M365 collaboration tools can be set up to scale across the OHT while being secure. This will leverage existing project resource, procure an external IT consultant/solutions architect (procurement needed, awaiting Digital funding support) and leverage in-kind support from technical resources from various ETHP partner organizations' IT team. 5. **ICP and HomeCare Project IT Supports Planning** –Support the planning and implementation of digital tools to support the workflows pertinent to these leading projects. This will leverage existing 3 project resources for digital planning in addition to collaborating with in-kind project resources from various streams and organizations involved in the ICP and HomeCare projects. 6. **Online Appointment Booking** - Increase the number of PCPs in East Toronto who are offering OAB to their patients, and increase overall usage and services available via OAB a. Assist PCPs and their clinics with onboarding and implementing OAB b. Increase overall usage rate and availability of services via OAB

	7. **AI Scribe** a. Assist PCPs with onboarding and deployment of AI scribe into their clinical workflow b. Review and evaluate the use and benefits of AI scribe tools
Key Partners Involved	1. **ETHP Collaborate** – Michael Garron Hospital, WoodGreen and VHA 2. **Digital Support Model Development** – MGH, VHA, WoodGreen, South Riverdale, Etc. 3. **Community Members Digital Guide Development** – MGH, WoodGreen and community members 4. **M365 Architecture Planning –**MGH, VHA, WoodGreen, other partner organizations on M365 and external consultants 5. **ICP and HomeCare Project IT Supports Planning –** MGH, OH and other partners who are involved in the ICP and HomeCare projects 6. **Online Appointment Booking -** EasT-FPN, other OHTs via community of practice, OAB vendors 7. **AI Scribe** - EasT-FPN, other OHTs and partners (eHealth Centre of Excellence, UofT DFCM), product vendor (Mutuo Health)
Resources Required [OPTIONAL]	*Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)* 1. **ETHP Collaborate** – will require funding for ETHP Collaborate Administrator and ongoing IT Support, software licensing and development support. 2. **Digital Support Model Development**– in kind resources from partners to be share for planning and execution 3. **Community Members Digital Guide Development**– in kind project resources from partner organizations. Funding will be required to support the recruitment and use of community members via the community ambassadors program. 4. **OHT M365 Backbone Architecture Planning** – in kind project resources and technical resources from partner organizations. Funds needed to procure an external IT consultant/solutions architect. 5. **ICP and HomeCare Project IT Supports Planning** – Leverage existing funded project resources from leading projects and in-kind project resources from organizations involved in the ICP and HomeCare projects.

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	6. **Online Appointment Booking -** pending OH funding for change management, as well as to support new licenses and continued support of existing licenses 7. **AI Scribe** – PM resourcing, vendor support and physician time across the implementation areas.

East Toronto Health Partners

4.0 OHT Community Engagement

Planned Community Engagements (including FNIMUI populations, Francophone populations, Black and racialized communities and other equity-deserving communities, including 2SLGBTQIA+, people with disabilities, newcomers and refugees, and people experiencing homelessness) [OPTIONAL-Requested by I12 OHTs]	
Complete the following:	
Objective	Strengthen ETHP Advisory Network's capacity to support ETHP's process to designation.
Annual Goal/Target	Involve patient/ caregiver advisors in Operational Plan development and implementation
Key Partners Involved	ETHP Anchor partners/ Leadership team, Community Advisory Council
Milestones	Community members participation in ETHP planning sessions Collaborate with Indigenous Primary Health Care Council (training and Indigenous Engagement framework) Establish Substance Use and MH Advisory Group Connect ETHP Advisory network and the ETHP EDI COP Leadership training for advisors (support participation in OHT Governance)
Description of Activities	Support patient/caregiver advisors' involvement in the Operational Plan development and implementation Identify training opportunities for indigenous cultural safety; develop indigenous engagement framework and develop relationships with Indigenous organizations / leaders in the community. Identify, recruit and onboard People with Lived Experience (PWLLE) of Substance Use and MH to join the Substance Use and MH advisory group Support the implementation of the ETHP EDI framework by connecting patient/ caregiver advisors to the ETHP EDI COP and encouraging their participation in the COP Identify leadership training opportunities for patient/caregiver advisors to support their participation in the ETHP governance structures.
Resources Required [OPTIONAL]	*Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)* Engagement budget for the advisors' honoraria and additional funds for training (indigenous cultural safety, leadership training) Leadership team and backbone team support

East Toronto Health Partners

<table>
<tr><th colspan="2">OHT Equity Education Requirements</th></tr>
<tr><td colspan="2">Complete the following:</td></tr>
<tr><td>Objective</td><td>1. Demonstrate that OHT staff have completed the following education:
• Indigenous Cultural awareness and safety training;
• EIDA-R education and training (e.g., anti-racism, anti-Black racism, cultural and linguistic sensitive care training, 2SLGBTQIA+ Rainbow Health Ontario courses, and general health equity); and,
• Active Offer.</td></tr>
<tr><td>Annual Goal/Target</td><td>100% of the ETHP backbone team will have completed Indigenous Cultural Safety Training</td></tr>
<tr><td>Key Partners Involved</td><td>VHA Home Healthcare (hosting ETHP Equity lead positions)</td></tr>
<tr><td>Milestones</td><td>Spring 2024: Register 20 ETHP partners and community members for San'yas Indigenous Cultural Safety Training sessions
Monthly: ETHP Anti-Racism and Equity Community of Practice</td></tr>
<tr><td>Description of Activities</td><td>• Align ETHP Anti-Racism and Equity stream to ETHP strategy and operations backbone team as a foundational component of all ETHP work
• Continue hosting ETHP Anti-Racism and Equity Community of Practice.
• Explore data governance models to help ensure ETHP is able to appropriately collect and manage equity-related data.
• Explore opportunities to build the capacity of ETHP members to advance anti-racism and equity work.

Dependent on Resources:
• Create a dedicated Anti-Racism and Equity staff role that supports the work of deeply embedding anti-racism and equity work in all areas of ETHP.
• Establish metrics for anti-racism and equity work with regular reporting for different workstreams and portfolios across ETHP.
• Enable leadership bodies to deliberately engage with anti-racism and equity.</td></tr>
<tr><td>Resources Required
[OPTIONAL]</td><td>Specify resources required and where resources might come from (e.g., external legal consultation, in-kind PM support from partners, OHT backbone etc.)</td></tr>
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5.0 OHT Risk Management

Strategic Risk	Description	Mitigation Strategies *(E) = Existing Strategy* *(N) = New Strategy*
Provide risk & risk assessment (likelihood & impact).	*Provide a description of the risk.*	*List all strategies to mitigate risk(s).*
• Likelihood: high • Impact: high	Limitations around OHT funding and uncertainty of longer-term funding supports	-Communicate risks to OH and Ministry -Seek additional sources of funding (grants, research grants, etc.)
• Likelihood: high • Impact: high	Unclear sustainability (funding & system enablers) for ICPs, innovations, and home care programs	-Ensure that short-term funding supports coordination rather than direct services (to reduce impact if funding ends or is reduced)
• Likelihood: medium • Impact: medium	Many partners have very stretched budgets, and limitations to 'in kind' contributions	-Recognize limited resources and align activities so that OHT goals are organizational goals.
• Likelihood: medium • Impact: medium	Insufficient change management supports. Important to ensure OHT work isn't subsumed by organization-level cultures and pressures	-Change leadership activities and thought leadership in integrated care.
• Likelihood: high • Impact: medium	Systemic barriers to embedding Population Health Management approaches within partner organization cultures, strategy, and accountabilities	-Advocate for removal of system barriers.
• Likelihood: high • Impact: high	Pace of implementation (OH deadlines for OHT deliverables) is not conducive to co-design and community engagement	-Communicate transparently around the constraints of funding deliverables and deadlines, demonstrating commitment to engagement and co-design.

• Likelihood: medium • Impact: high	Impact of over-measuring and over-reporting, detracting from our ability to move forward with key work. This is particularly challenging with respect to equity-deserving communities and primary care sector.	-Negotiate for simplified reporting and measurement approaches and retain focus on key work deliverables as much as possible.
• Likelihood: high • Impact: medium	Balancing local priority initiatives with provincial OHT deliverables, remaining accountable to the community.	-Communicate transparently around the constraints of funding deliverables and deadlines, demonstrating commitment to engagement and co-design.
• Likelihood: high • Impact: high	Lack of strong and consistent vision for transformational change within the current framework of expected OHT activities, with limited funding available.	-Communicate transparently around our vision and our constraints