East Toronto Health Partners

ETHP 2024-25 Acceleration Operating Plan

Summary and Highlights

October 2024

Operating Plan for 2024/25

EXECUTIVE SUMMARY

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

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ETHP Goals / Targets

Section of Plan	ETHP Goal or Target
ICP **Chronic Disease**	Interim Goals: People enrolled into the program vs offered Long term goal: Readmission rates (25% reduction, 6-12 months post launch)
Primary Care Access & Attachment	Contribute to the Ontario Health Toronto Regional goal of attaching 55,000 unique clients to primary care
System Navigation	Integrate navigation into a minimum of 50% work projects/initiatives across the ETHP portfolios
Cancer Screening	Achieve cancer screening participation rates as outlined in 2024-25 cQIP: 0.1% increase
ADDED: Mental Health & Substance Use	cQIP indicator: 1st presentation to ED for Mental Health & Substance Use – decrease 0.01
ADDED: Transitions in Care	-Achieve key performance metrics of MGH2Home Program (240 clients served within the fiscal year) -cQIP indicator: Alternate Level of Care for ETHP attributed population – decrease % ALC by 0.1

Section of Plan	ETHP Goal or Target
Patient Family Caregiver Involvement	Involve ETHP's Community Advisory Network members in all OHT initiatives and projects
Home Care Readiness	-Achieve all elements of upcoming Home Care readiness and delivery plan by March 31 2025 -Launch Integrated Neighbourhood Home Care Program (Leading Project) in ETHP
Primary Care Networks	-Recruitment and Retention -Access pathways to specialists and community resources -IPCT expansion
OHT Membership	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.
Digital Plan	Maturing our digital network to strengthen our operating support model and establishing a path for how our digital architecture must evolve
Community Engagement	Involve patient/ caregiver advisors in Operational Plan development and implementatio
Equity Education	100% of the ETHP backbone team will have completed Indigenous Cultural Safety Training

Operating Plan - ICPs and Chronic Disease

Integrated Care Pathways / Chronic Disease Prevention & Management

Implement two Integrated Clinical Pathways starting with COPD, then CHF. Evolution of PCCRT to EastTCaN, a locally identified model of care designed in collaboration with partners and community to support better chronic disease management. See next slide for details.

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.

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East Toronto Care Network (EastTCaN) COPD Pathway- Phase 1

Health and Social Care: Building a healthier and more equitable East Toronto - enabling every person and neighbourhood to thrive

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Phase 1: Acute Care

Remote Care Monitoring

RCM for Post Acute Care Admissions

★ *QS11-Follow-up after an acute exacerbation of COPD*

Phase 2: Primary Care

Access Administrators

Clinical Care Facilitators

★ *QS2- Comprehensive Assessment*
QS3-Goals of Care and Individual Care Planning
QS10- Management of Acute Exacerbations of COPD

Phase 3: Community

ETHP Collaborate

Shared Care Planning Tool for Collaborative, Coordinated Care Management

★ *QS5-Promote Smoking Cessation*

Home and Community Care

Primary Care

★ *QS7- Vaccinations*

Medication Management

★ *QS6-Pharmacological Management*

Person

★ *QS4-Education and Self-Management*

Diagnostics

★ ***QS1- Diagnosis confirmed with spirometry***

Family and Caregiver

Community Health Ambassadors

Respirology

★ ***QS8- Specialized Respiratory Care***
QS13- Palliative Care

Key Features

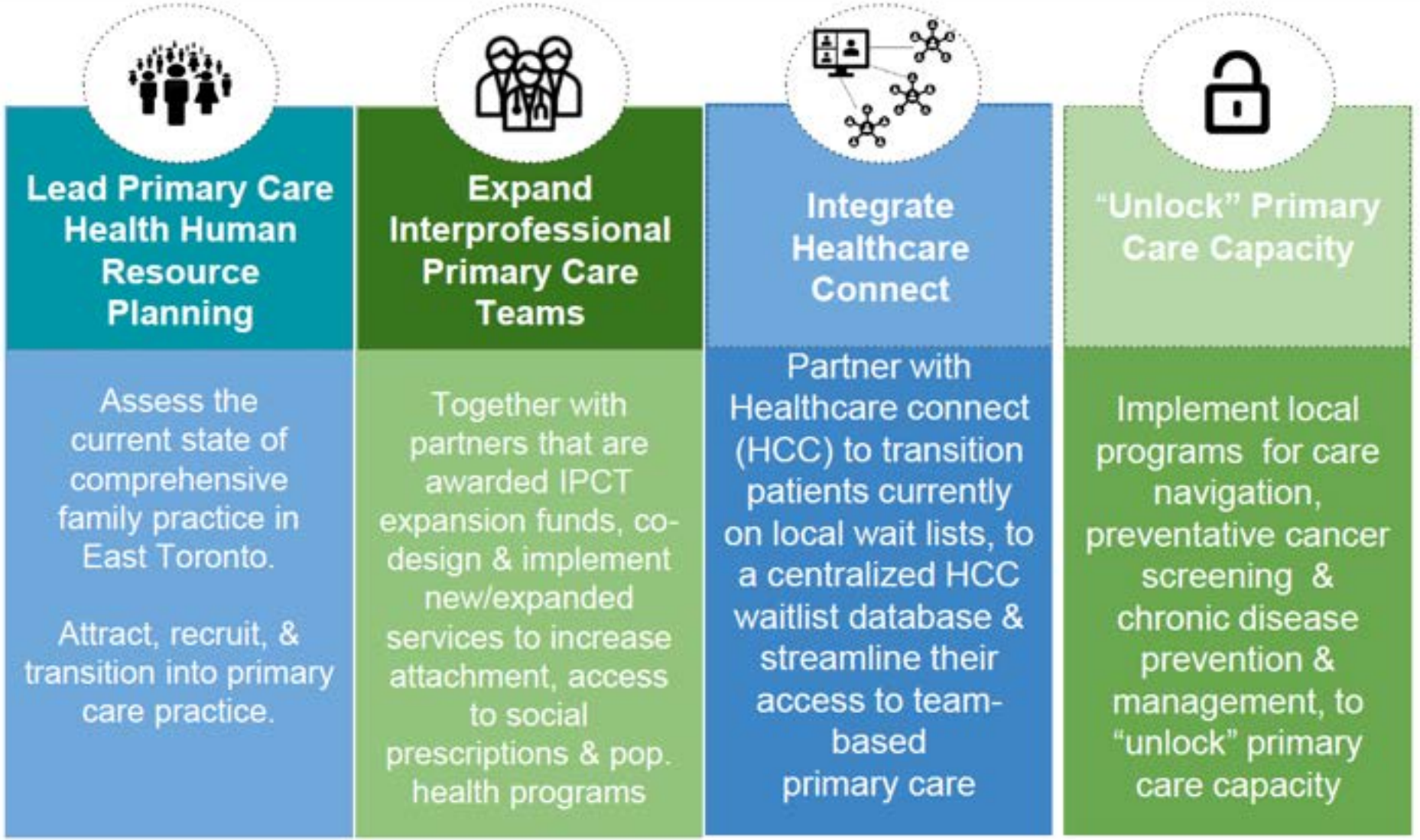
- Holistic Case Management
- Rounding
- Team Based care
- Peer Support
- Facilitated Support Groups
- Education

Referral	Registration	Ongoing Assessments and Custom Care Planning	Outcomes	★ Quality Statement (Gaps)
• Phased referral sources into program	• Patient/Client Profile: SDoH, Self-efficacy, Access to services (caregiver, virtual), care journey, etc.	• Evidence-based care management • Understanding care needs • Making service connections (person-centered care) • Self-management resources • Regular check-ins	✓ Reduced Acute Care Utilization (ED, Beds) ✓ Self-Mastery ✓ Better Quality of Life ✓ Quintuple Aim	• **QS9- Pulmonary Rehabilitation** • Q12- Pulmonary Rehabilitation After Hospitalization • QS14-Long-Term Oxygen Therapy

Operating Plan – Primary Care Access & Attachment

EasT-FPN
EAST TORONTO FAMILY PRACTICE NETWORK

EasT-FPN & ETHP Primary Care Access & Attachment Strategy



Operating Plan – System Navigation

Navigation: FY 2024/25 Operating Plan

Initiative	Objectives and Plan	Resources (In Kind)	Resources (ETHP supported)	Resources (Needed)	Challenges (capacity, capability, gaps, dependencies, risks)
Online Directory	Maintenance of Toronto Health and Social Services Directory (Sustainability plan for Feb 13/25 onward)	8 OHT contributions in 2023	ETHP Navigation Leads	Contract extension past 2025	Need for program & service updates (annual cadence atm) Natural language processing feature End date of contract Community feedback re: user experience (lacking real-time capacity/wait-time info)
CoP	Continuation of Community of Practice monthly meetings	CoP members (Kendelle)	ETHP Navigation Leads		Active participation form group ETHP initiatives are not coming together to consult/utilize CoP for navigation projects
Advocacy for service capacity transparency	*Advocate for a (digital/online) platform for both HP & community to access real-time information*		*ETHP Navigation Leads*	*Platform, funding, & commitment across region*	*Region-wide buy-in for optimal utility; need for ongoing timely updates from partners*
IPAC Surge Repository	**Ongoing utilization & partner onboarding** **Continued updates & posting of resources** **Reflect on & determine best way to support IPAC & have info disseminate to partners**	**ETHP Sharepoint IPAC Lead**	**ETHP Nav Leads**	**Surge Coordinator**	**Tracking use/uptake difficult to assess**
Portfolio/ Partner collaboration advisory & support	1. **With MH & Substance use CQIP:** Improve connections to community services: explore specific initiatives/interventions. 2. **With EasT-FPN:** 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). 3. **With ETHP Digital portfolio:** 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.	(Kendelle)	ETHP Nav Leads		

Operating Plan – Cancer Screening

Cancer Screening

Goal: achieve cancer screening participation rates, as outlined in ETHP's 2024-25 collaborative Quality Improvement Plan

- 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.

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Operating Plan – Local Priorities

Mental Health and Substance Use cQIP

- 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.
- Initiate a proposal and working group for a Taylor-Massey youth wellness hub.
- Develop and implement a youth outreach team.
- Pursue integrated care model and funding for substance use.
- 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

Transitions in Care cQIP

- 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.
- Supporting Integration of EASTCAN, MGH2Home and Home Care Leading Project (HCLP)

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Operating Plan - PFC Involvement

Patient, Family, & Caregiver Involvement

Objective: **Implement an advisory council comprised of patients, families and caregivers within the OHT local community.**

- ETHP has established 6 Advisory Councils connected in ETHP's advisory network.

Activities:

- 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.
- 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)
- ETHP advisory network members participate in bi-annual ETHP planning sessions with partner organizations.
- Ad-hoc consultations with ETHP Advisory networks as needed based on ETHP's progress towards designation.

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Operating Plan – Home Care Readiness

Complete a Home Care Readiness and Delivery Plan aligned with guidance, when available

ETHP Goal:

- Achieve all elements of upcoming Home Care readiness and delivery plan by March 31 2025, including confirmation of the governance approach (**lead Health Service Provider**) for future home care delivery within East Toronto Health Partners.

- **Support hospital to home transitions for 240 patients** (ALC designated or at risk for ALC) with up to 90 days of tailored home care supports via MGH2Home Program

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Operating Plan – Primary Care Networks

Primary Care Networks

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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Operating Plan – OHT Membership

OHT Membership

Objective: 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.

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.

ETHP Goal: 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.

Involved Partners: A call for volunteer participation in a Governance Planning Committee was sent out to the entire ETHP. 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 a minimum of 6 months.

ETHP Activities

- Schedule Governance Planning Committee working sessions to co-design a governance framework that builds trust and enables 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.

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Operating Plan – Digital Plan

Develop an OHT Digital Plan

Milestones:

1. Completion of ETHP Collaborate Care Planning Tool – end of 24/25
2. Draft Digital Support Model – end of 24/25
3. Community Members Digital Guide to Navigating ETHP Tools – end of 24/25
4. Digital Strategy 2025-2027 – end of 24/25
5. OHT M365 Backbone Architecture – end of 24/25
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 - end of FY 24/25
7. Membership engagement – deploy a new CRM platform to improve tracking PCN membership changes and engagement activities - Q3 of FY 24/25
8. 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
9. Hypercare – develop process for connecting non-credentialed community users with specialists - end of FY 24/25

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Operating Plan – 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)

Goal: Involve patient/ caregiver advisors in Operational Plan development and implementation

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.

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Operating Plan – Equity Education

OHT Equity Education Requirements

Goal: 100% of the ETHP Backbone Team will have completed Indigenous Cultural Safety Training

Milestones:

- Expand membership and appoint new co-chairs of ETHP Anti-Racism and Equity Committee until resources are established to support further embedding of anti-racism and equity priorities and principles into 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.

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Risk

- Uncertainty around funding
- Unclear sustainability (funding & system enablers) for ICPs, innovations, and home care
- Many partners have very stretched budgets, and limitations to ‘in kind’ contributions
- Important to ensure OHT work isn’t subsumed by organization-level cultures and pressures
- Systemic barriers to embedding Population Health Management approaches within partner organization cultures, strategy, and accountabilities
- Pace of implementation (OH deadlines for OHT deliverables) is not conducive to co-design and community engagement

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