September 18, 2020

The Honourable Christine Elliott, M.P.P.
Deputy Premier and Minister of Health
777 Bay St. 5th Floor
Toronto, ON M7A 2J3

RE: Mid-West Toronto Ontario Health Team Submission

Dear Minister Elliott,

Please find enclosed our submission for the Mid-West Toronto Ontario Health Team (MWT-OHT). The MWT-OHT represents a self-organized group of strategically and philosophically aligned community service providers, primary care providers and hospital partners. We share an interest in advancing collaboration and shared accountability for patients residing in our uniquely urban community and attributed to our network of providers.

The MWT-OHT represent a complex network, which includes 575,027 patients in 47 Primary Care Enrollment Models (PEMs) aligned to UHN, Sinai Health System, Women's College Hospital and the Centre for Addictions and Mental Health. The MWT-OHT will build toward caring for this entire attributed population using a stepwise approach.

We believe, if we can design a health care system that works for our most structurally vulnerable populations, then we will be designing a health care system that works for everyone.

Our near-term focus is on improving care coordination and support for marginalized communities who choose to seek services within the Mid-West Toronto region. Our goal is to co-design care with individuals with lived experience to actively remove the systemic barriers that prevent meaningful attachment to primary care, that obscure clear access points to the network of providers, and that prevent seamless transitions in care between providers.

Beyond achieving the Quadruple Aim for our entire attributed population and providers within our network, our long-term goal is to embed a true population health approach. By leveraging the assets within our partnership, the MWT-OHT will create a comprehensive network of care that measures success on more than just the traditional set of health indicators. The network, in collaboration with patients and marginalized communities, will address the social determinants of health for meaningful improvements to our populations' general health and wellbeing.

Integrating primary care will also be a core principle in our OHT, consistent with global evidence that high performing health systems rely on the central role of primary care. Beyond ensuring that primary care providers are meaningfully engaged in the OHT planning process, we will also ensure their services are integrated into the network by building off the success of our existing primary care integration

initiatives SCOPE (Seamless Care Optimizing the Patient Experience) Team Care and SPiN (Solo Practitioners in Need). These programs have created central navigation hubs that offer patients faster access to specialist care and community support services.

In addition to planning for the future of our Ontario Health Team, the enclosed application also details the coordinated approach we will take in supporting our community through the COVID-19 pandemic and upcoming flu season. With numerous lessons learned from our coordination efforts in Wave 1, we are equipped to ensure that our most structurally vulnerable communities have the supports they need to live safely through the pandemic.

Overall, we are deeply motivated by the collective, passionate and transparent approach taken by our partners in developing this submission and look forward to being a leader in the development of Ontario Health Teams.

On behalf of the Mid-West Toronto Ontario Health Team Partners,

John Yip
President & CEO, Kensington Health.

Dr. Kevin Smith
President & CEO, University Health Network

cc: Helen Angus, Deputy Minister of Health
Melanie Fraser, Associate Deputy Minister of Health Services
Phil Graham, Executive Lead, Ontario Health Teams
Matthew Anderson, CEO, Ontario Health
Tess Romain, Regional Lead Toronto, Ontario Health

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September 17, 2020

The Honourable Christine Elliott, M.P.P.
Deputy Premier and Minister of Health
777 Bay St. 5th Floor
Toronto, ON M7A 2J3

Dear Minister Elliott,

We are writing this letter in support of the Mid-West Toronto Ontario Health Team (MWT-OHT) application to become an Ontario Health Team. The Toronto Central LHIN has been actively contributing to the Mid-West Toronto OHT and supports their vision and principles to integrate care for patients and caregivers.

The Toronto Central LHIN has participated at many levels in the engagement and planning activities of the MWT-OHT in their work to become one of the province's Ontario Health Teams, including being a regular participant at the MWT-OHT Executive Partner Advisory Committee (EPAC). We are confident that the MWT-OHT partners are committed to building a system that works for the most vulnerable and addresses the gaps in care for structurally vulnerable populations ubiquitous in downtown Toronto.

The MWT-OHT team has developed a comprehensive strategy for meaningful engagement with patients, caregivers and community stakeholders. These opportunities for engagement have allowed the voices of the patients to inform the application and directly influence the planning for the future state of care in Mid-West Toronto.

We are confident that MWT-OHT will continue to meaningfully engage all partners in Mid-West Toronto and the application from MWT-OHT has our support. We look forward to continuing to work with MWT-OHT in the months ahead to help transition clients to integrated care models to enable high quality patient-centred care for patients and caregivers in Mid-West Toronto.

Signed,

Tess Romain
Transitional Regional Lead (Toronto, and CEO for Toronto Central LHIN) Ontario Health

Cc: Phil Graham, Executive Lead, Ontario Health Teams, Ministry of Health
Cc: Matt Anderson, President and CEO, Ontario Health

Ontario

Gayle Bursey
Director, Strategy and Preventive Health

Dr. Eileen de Villa
Medical Officer of Health

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September 17, 2020

The Honourable Christine Elliott
Deputy Premier and Minister of Health
777 Bay St., 5th Floor
Toronto, ON M7A 2J3

Dear Minister Elliott:

Re: Ontario Health Team – Mid-West Toronto

On behalf of Toronto Public Health's Medical Officer of Health, Dr. Eileen de Villa, I am writing this letter of support for the Mid-West Toronto team's full application to become an Ontario Health Team. Toronto Public Health has a history of working together with partner organizations in the Mid-West Toronto team.

The application satisfactorily demonstrates plans for encouraging comprehensive patient and community engagement as critical partners in population health. I have confidence that a Mid-West Toronto Ontario Health Team, at maturity, will work towards delivering a full and coordinated continuum of care to its residents.

We look forward to continuing to work with these organizations to support the development and implementation of a Mid-West Toronto Ontario Health Team upon approval of the full application, if granted.

Sincerely,

Gayle Bursey
Director, Strategy and Preventive Health

cc: Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health

MID-WEST TORONTO ONTARIO HEALTH TEAM

We believe, if we can design a health care system that works for our most structurally vulnerable populations, then we will be designing a health care system that works for everyone.

Primary Contacts

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Ontario Health Team: Full Application

Introduction

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

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

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

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

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

OHT Implementation & COVID-19

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

Information to Support the Application Completion

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

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

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

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

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

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

Participation in Central Program Evaluation

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

Submission and Approval Timelines

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

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

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

Additional Notes

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

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

Key Contact Information

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: John Yip
	Title: President & CEO
	Organization: Kensington Health
	Email: jyip@kensingtonhealth.org
	Phone: 416.963.9640 x1010

Primary contact for this application *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Kevin Smith
	Title: President & CEO
	Organization: University Health Network
	Email: kevin.smith@uhn.ca
	Phone: (416) 340-3307

Key Contact Information

Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Justine Humphries
	Title: Director, Corporate Planning and Communications
	Organization: Kensington Health
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Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Lori Seeton
	Title: Manager, Strategy
	Organization: University Health Network
	Email: lori.seeton@uhn.ca
	Phone: 416-262-4476

1. About Your Population

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

1.1. Who will you be accountable for at maturity?

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

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

Maximum word count: 500

As partners of the Mid-West Toronto OHT (MWT-OHT), we approach this submission as a truly transformative opportunity to address the gaps in care for structurally vulnerable populations, ubiquitous in downtown Toronto. We operate under the collective belief that by creating a healthcare system that works for the most vulnerable, we create a system that achieves population-based health for our entire attributed population.

We represent a complex, often disconnected network, which includes 575,027 patients in 47 Primary Care Enrollment Models (PEMs) aligned to UHN, Sinai Health System, Women's College Hospital and the Centre for Addictions and Mental Health. There is a high degree of in-migration from surrounding regions as less than 80% of the attributed population lives in the City of Toronto and an unknown subset of this 80% lives specifically in the mid-west Toronto geographic area where the vast majority of our provider partners are located. Adding further complexity, the majority of PEMs within our network (more than 70%) have some patients who are aligned to different OHT networks.

The complex referral patterns expected within a large urban centre will present unique challenges in becoming clinically and fiscally accountable for this entire attributed population at maturity. Integrating primary care will be a core principle in our OHT, consistent with global evidence that high performing health systems rely on the central role of primary care. Though some degree of alignment is anticipated over

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

time as we strengthen our collaboration and integration with primary care, it is not our intention to manipulate physician referral patterns as it is critical for primary care providers and their patients to maintain agency and choice.

The MWT-OHT will build toward caring for the entire attributed population using a stepwise approach. Our near-term focus is on improving care coordination and support for marginalized communities who choose to seek services within the Mid-West Toronto region. Our goal is to actively remove the systemic barriers that prevent meaningful attachment to primary care, that obscure clear access points to the network of providers, and that prevent seamless transitions in care between providers. In the medium term, once we accomplish the aforementioned goal, the MWT-OHT will ensure that all the provider partners are plugged into these systems to become truly accountable to the attributed population. (See Appendix 2 for Population Planning Horizons).

Beyond achieving the Quadruple Aim for our entire attributed population and providers within our network, our long-term goal is to embed a true population health approach. Our population health approach and infrastructure will be developed in the coming years to take action directed toward the health of the entire population[1] and to explicitly and judiciously apply population health approaches to care for individual patients and to the design of our health care systems.[2]

1.2. Who will you focus on in Year 1?

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

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

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

Maximum word count: 500

Prior to COVID-19, there was broad consensus that our Year 1 Populations include Frail Seniors, Individuals with Mental Health and Substance Use Challenges, and the

Homeless and Under-housed. The pandemic brought clarity in highlighting some critical principles for our OHT, including:
1. Confirming that our priority populations are the most disproportionately affected by fractured models of care.
2. Revealing key subpopulations (ie. BIPOC) within these groups that require immediate action from our Team.
3. Forcing rapid planning and development of collaborative infrastructure to act as a foundation from which we can develop our OHT.
The following sections detail our Year 1 foci.

1) Frail Seniors:
Our focus is helping seniors age in place; whether in their home, a long-term care home, or another setting. The LTC resident rate in MWT (87.5 per 1000 for people over 75) is higher than the provincial rate of 68 per 1000. Our efforts will therefore aim to keep the 44,237 individuals 75+ who are attributed to our Team safe and healthy in their homes longer. For the 101,107 seniors (65+) who are attributed to our Team, we will aim to reduce ALC days as well as ED and hospital admissions.

HCC: Throughout the pandemic, more frail seniors began isolating at home increasing their risk of hospitalization and LTC admission. Accordingly, our partners augmented supports to enable people to thrive at home. These supports are mostly provided to frail seniors 80+ (currently 27,527 attributed to our OHT) that have high care needs.

In Year 1, we will:
- Focus on improving home support for seniors that West Neighbourhood House serves: 3,717 seniors, of which 1,425 are 80+.
- Accelerate virtual and focused support for primary care providers to expand their capacity to manage frail homebound seniors.

LTC: As of September 7, COVID-19-related deaths reported for residents of LTC homes make up 64.6% of all COVID-19-related deaths in Ontario. This disproportionate mortality rate has strengthened our resolve to partner in improving health outcomes of LTC residents. This includes continuing the successful Hospital Resource Partnerships (HRPs) between Hospitals and LTC homes in our region.
In addition to the HRPs, the LTC+ program is charged with providing virtual 24/7 tertiary specialist and geriatric medicine support to residents and their LTC care teams, avoiding costly and disruptive transfers to hospital.

In Year 1, we will focus our coordination and performance measurement efforts on residents of four homes that are partnered with MWT-OHT hospitals and are actively

utilizing LTC+, including Kensington Gardens and totalling approximately 1000 residents.

2) Those experiencing homelessness:

Proposed New Paragraph:
In the MWT region, there are 13 shelters housing approximately 488 people per night; 23 drop-in centres that see approximately 1100 per year[1]; 3 respites sheltering 108 people per night; and 6 hotels acting as temporary COVID-19 response with capacity for approximately 500 people. Recognizing that there is overlap in the above counts, this represents roughly 2200 daily interactions with our partners and therefore 2200 opportunities for us to facilitate meaningful attachments to primary care, mental health and substance use services, and case management supports. Individuals experiencing homelessness have traditionally low access to primary care in Toronto (39.5% unattachment rate).[2]

3) Individuals with Substance Use Challenges:

The discovery work led by people with lived experience and the UHN OpenLab Team revealed long wait times between services as one of the biggest causes of relapse or other poor outcomes amongst those with substance use challenges. In Year 1, we will focus on closing transition gaps for people utilizing the UHN Withdrawal Management Service, which sees 738 annual admissions - a small subset of the nearly 4,000 people in the MWT region living with substance use

1.3. Are there specific equity considerations within your population?

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

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

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

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

The large population of the MWT-OHT is defined by several socioeconomic factors that make overcoming barriers to our health care system challenging and, in some cases, nearly impossible. Below is some key sociodemographic data that defines the MWT and its neighbourhoods, followed by specific sociodemographic data for Year 1 populations. These health equity considerations will be critical in designing our OHT; recognizing that a system that works for the most vulnerable will work for everyone.

Mid-West Toronto Sub-Region Data:
Cultural Diversity:
• 36.7% of the population identifies as a visible minority: 30.4% as Chinese, 14.9% as South Asian, and 14.6% as Black.[1]
• 10,547 individuals identify as Indigenous.[1]
• Higher rate (5.4%) of individuals with no knowledge of English or French compared to Toronto Central average. Most prominent languages spoken in the home are Portuguese, Mandarin and Cantonese. [1]

Gender and Sexuality:
• According to 2016 census data 51% identifies as female, while 49% identifies as male.
• Of the hospital and CHC patients in MWT for whom equity data was collected and responses were provided in Q4 2019-2020,
• 0.2% of hospital and 2% CHC patients identified as trans, gender diverse, or non-binary. [2]
• 4.5% of hospital and 9.5% CHC patients identify as LGBTQ2S. [2]

Socioeconomic Diversity:
• 18.7% fall below the Low-Income Measure-After Tax (LIM-AT)[1], with Kensington Chinatown, South Parkdale, and Bay Street Corridor having more than 30% of their population falling below the LIM-AT. [3]
• 16 of the neighbourhoods within the MWT geography have higher rate of households in Core Housing Need than provincial rate. Four neighbourhoods (South Parkdale, Oakwood Village, Kensington Chinatown, and Keelesdale Eglinton West) have more than 25% of their population in Core Housing Need.[3]
• 2,070 uninsured individuals accessed care through 5 CHCs [1]
• There is a 6.6% unemployment rate. [1]

Those experiencing homelessness and Underhoused:
Given the transient nature of the underhoused population it is difficult to capture data specific to MWT region. The MWT-OHT is using the Toronto's Street Needs Assessment (SNA) as a proxy. It is a survey and point-in-time count of people experiencing homelessness in Toronto, providing a snapshot of the population on April 26, 2018.[4]

Cultural Diversity:

• The number of people experiencing homelessness in Toronto is due, in large part, to a significant increase in refugee/asylum claimants. 52% reported coming to Canada as an immigrant, refugee/asylum claimant, or temporary resident.
• Over 75% of respondents reported feeling most comfortable speaking English.
• Approximately 65% of all respondents identified as members of racialized groups, the largest percentage identify as Black (40%). 51% of non-refugee respondents (compared to 94% of refugee respondents) identified as a member of a racialized group.
• Indigenous people represent 16% of the overall population experiencing homelessness compared to up to 2.5% of the population of Toronto.

Gender and Sexuality:
• 11% of respondents identified as LGBTQ2S, while 24% of youth identified as LGBTQ2S.
• 3% of respondents identify as transgender, Two-spirit and genderqueer/gender non-conforming.
• Men make up 54% of the population experiencing homelessness while women represent 42%.

Pursuit of Permanent Housing:
• 94% of those experiencing homelessness indicated a desire for permanent housing.
• 6% of the total homeless population lives outdoors.

Health Conditions:
• 57% reported having one or more health condition such as diabetes, arthritis, heart condition, physical disability, or mental health issue. This was highest among outdoor respondents (80%) and 24-hour respite site respondents (76%).
• Seniors (individuals 60+) make up 10% of the homeless population, those 65+make up 5% of the population, and those 70+ make up 2% of the homeless population.
• 38% of respondents reported interacting with the ED, 27% reported being hospitalized, and 27% reported using an ambulance.

Recognizing and responding to the specific equity considerations for this population will be critical in creating seamless pathways to care and enabling meaningful attachment to non-judgmental, culturally safe health and social services including Primary Care, MHSU supports, as well as Case Management Support. However, the MWT partners recognize that the vulnerability associated with those experiencing homelessness within the health care system is a symptom of homelessness itself and cannot be overcome without affordable housing solutions and strategies.

Frail Seniors:
The frail seniors population has a high proportion of immigrants, people who speak English as a second language, people with low literacy, and those who are working class. Our Team recognizes the importance of offering high quality, accessible services in multiple languages for clients, patients, and their families and communities, as well as care that is culturally appropriate. This will be true for our whole attributed population, but especially for our frail seniors. Gender diversity will also be especially important to consider as women make up a larger proportion of frail seniors.

Cultural Diversity:
• 75.4% of seniors living in MWT are immigrants. Of those, 6% immigrated in the last five years [5]
• 27.3% identify as a visible minority. 37.7% identify as Chinese, 16.8% identify as Black, and 10% identify as Latin American. [5]
• 23.3% have no knowledge of either official language. Most prominent non-official languages spoken include Portuguese, Italian, Cantonese, Spanish, and Mandarin.[5]
• 1% of seniors in MWT identify as Indigenous. [5]

Gender:
• Females make up 54% of the population 65-74 years of age, and 60% of the population 75+. [5]
• Females also make up nearly 71% of residents in Long-Term Care homes.[6]

Socioeconomic Diversity:
• In close alignment with the MWT as a whole, 18.4% of seniors in MWT fall below the Low-Income Measure-After Tax [5]
• 8.8% of seniors in the MWT live alone, 29.8% of whom experience difficulties with Activities of Daily Living [5]

Mental Health and Substance Use:
The MWT partners recognize that people experiencing mental health and substance use challenges experience the system differently and seek different care routes based on their gender, skin colour, socioeconomic status and first language. Unfortunately, diversity data for mental health and substance use services are currently limited in availability and may have data quality concerns. The MWT partners will explore recommendations to improve the quality of data available.

Cultural Diversity:
• 60.8% of substance use-related admissions to CAMH were by those identifying as White, 10.2% as Black, 4.3% as Indigenous, 5.4% as Asian, 2.9% as Middle Eastern, 2.5% as Latin[7]
• In 2019-20, CAMH Interpretation Services received 4670 requests from CAMH staff for interpreters covering 72 different languages. The top 5 most frequently requested languages were: Spanish, Arabic, Vietnamese, Cantonese and American Sign Language. [8]

Gender:
• Of the 1,129 people who received Case Management services for Substance Use from MWT-OHT partners over the past year, 59% of them identified as male and 41% as female [9]
• Of the 3,021 people who accessed Withdrawal Management Centres for Substance Use from MWT-OHT partners over the past year, 62% of them identified as male and 38% as female [9]

Socioeconomic Diversity:
• 32% of homeless individuals in Toronto identified that they had Mental Health conditions, while 27% reported having substance use challenges.

2. About Your Team

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

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

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

Given the important work ahead in the Fall in preparation for cold and flu season and the potential for wave 2 of COVID-19, teams should look at efforts to engage with public health and congregate care settings including long-term care, and other providers that will allow teams to leverage partnerships that support regional responses and deliver the entire continuum of care for their patient populations.

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

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

2.2. Confirming Partnership Requirements

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

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

2.1.1 Primary Care Partnerships

NAME OF GROUP/FHT *From dropdown list, select the name of the participating group or FHT, as registered with the Ministry or select 'solo fee-for-service' if not part of a group practice. If a group is not found in this list, add it to Other (column E).*	PHYSICIAN NAME (Last name, First name) *Providing the full list of your partner physicians will be critical for identifying which OHT attribution network the physician or PEM is affiliated and level of physician engagement*	PRACTICE MODEL *Select model type from dropdown list. If 'other' is selected, please specify model type in Other :*	OTHER *If the listed physician or physician group works in a practice model that is not listed, please indicate the model type here. Note here if a FHT is a member but not its associated physician practice(s) and vice versa.*
CCM - Comprehensive Care Group	Almasi, Behzad		CCM - Comprehensive Care Group
CCM - Comprehensive Care Group	D'Agrosa, Raffaele		CCM - Comprehensive Care Group
CCM - Comprehensive Care Group	Diaz De Molnar, Ana		CCM - Comprehensive Care Group
CCM - Comprehensive Care Group	Kandola, Monica		CCM - Comprehensive Care Group
CCM - Comprehensive Care Group	Kuisma, Michelle		CCM - Comprehensive Care Group
CCM - Comprehensive Care Group	Paulaitis, Christina		CCM - Comprehensive Care Group
CHC - ACCESS ALLIANCE	Bala, Vinchala	CHC - Community Health Centre	1 NP Amanda Verschuere
CHC - ACCESS ALLIANCE	Lukenda, Mike	CHC - Community Health Centre	
CHC - CENTRE FRANCOPHONE	Auger, Dominque		3NPs - Henri Rakoto, Micheline Thilault & Nneka Peters
CHC - CENTRE FRANCOPHONE	Gmora, Shawn W.		
CHC - CENTRE FRANCOPHONE	Norris, Mirelle		
CHC - CENTRE FRANCOPHONE	Raza, Ayesha		
CHC - DAVENPORT PERTH	Arruda, Amanda	CHC - Community Health Centre	2 NPs - Nicole Leung & Zahra Alvi
CHC - DAVENPORT PERTH	Garjardo, Paz	CHC - Community Health Centre	
CHC - DAVENPORT PERTH	MacCallum, Christie	CHC - Community Health Centre	
CHC - DAVENPORT PERTH	Weir, Michelle	CHC - Community Health Centre	
CHC - PARKDALE QUEEN WEST	Chowdhury, Muna	CHC - Community Health Centre	8 NPs - Rosie Henderson, Nghi Trieu, Sandra Pettey, Kim Reilly, Shona MacKenzie, Falko Schroeder, Melissa Abrams, Raymond Macaraeg
CHC - PARKDALE QUEEN WEST	Gilles, Alison	CHC - Community Health Centre	
CHC - PARKDALE QUEEN WEST	Glover, Alexander	CHC - Community Health Centre	
CHC - PARKDALE QUEEN WEST	Haque, Andalib	CHC - Community Health Centre	
CHC - PARKDALE QUEEN WEST	Kainth, Sonika	CHC - Community Health Centre	
CHC - PARKDALE QUEEN WEST	MacDonald, Mary Rose	CHC - Community Health Centre	
CHC - PARKDALE QUEEN WEST	Man, Thomas	CHC - Community Health Centre	
CHC - PARKDALE QUEEN WEST	Ochieng, Cindy	CHC - Community Health Centre	
CHC - PARKDALE QUEEN WEST	Rai, Nanky	CHC - Community Health Centre	
CHC - PARKDALE QUEEN WEST	Sandhu, Sherry	CHC - Community Health Centre	
CHC - PARKDALE QUEEN WEST	Siu, Maggie	CHC - Community Health Centre	
CHC - PARKDALE QUEEN WEST	Wong, Patrick	CHC - Community Health Centre	
CHC - PLANNED PARENHOOD	Alani, Rahima	CHC - Community Health Centre	4 NPs - Marisa DeLuca, Kristen Heise, Lindsay Mellor, Tania Correa
CHC - PLANNED PARENHOOD	Dupuis, Kaitlin	CHC - Community Health Centre	
CHC - PLANNED PARENHOOD	Lobo, Andrea	CHC - Community Health Centre	
FFS - HEALTH CHOICE CENTRES	Shabash, Osama	FFS - Solo fee-for-service	
FFS - SOLO FEE-FOR-SERVICE	D'Urzo, Anthony	FFS - Solo fee-for-service	
FFS - SOLO FEE-FOR-SERVICE	Etzkorn, William	FFS - Solo fee-for-service	
FFS - SOLO FEE-FOR-SERVICE	Ho, Michael	FFS - Solo fee-for-service	
FFS - SOLO FEE-FOR-SERVICE	Li, Dominic	FFS - Solo fee-for-service	
FFS - SOLO FEE-FOR-SERVICE	Lim, Jason	FFS - Solo fee-for-service	
FFS - SOLO FEE-FOR-SERVICE	Mingo, Nancy	FFS - Solo fee-for-service	
FFS - SOLO FEE-FOR-SERVICE	Mishriki, Nahed	FFS - Solo fee-for-service	
FFS - SOLO FEE-FOR-SERVICE	Soboloff, Michael	FFS - Solo fee-for-service	
FFS - UNION HEALTH	Dhanji, Soreya	FFS - Solo fee-for-service	
FFS - UNION HEALTH	Lakhoo, Sheila	FFS - Solo fee-for-service	
FFS - UNION HEALTH	Nowak, Dominic	FFS - Solo fee-for-service	
FFS - UNION HEALTH	Sauret, Ariana	FFS - Solo fee-for-service	
FHG - Bloor Medical Clinic	Flomen, Marcy	FHG - Family Health Group	
FHG - Bloor Medical Clinic	Fogel, Bernard	FHG - Family Health Group	
FHG - Bloor Medical Clinic	Hanet, Stephen	FHG - Family Health Group	
FHG - Bloor Medical Clinic	Kaplovitch, Harvey	FHG - Family Health Group	
FHG - Bloor Medical Clinic	Mawji, Elysha	FHG - Family Health Group	
FHG - Bloor Medical Clinic	Shechtman, Grant	FHG - Family Health Group	
FHG - Bloor Medical Clinic	Weisbrod, Maxwell	FHG - Family Health Group	
FHG - Chinatown Medical Centre	Chan, King Sun	FHG - Family Health Group	
FHG - Chinatown Medical Centre	Fung, Kan Ying	FHG - Family Health Group	
FHG - TNT FHG	Nhan, Toan	FHG - Family Health Group	
FHO - BALMORAL HEALTH GROUP (ROSEDALE)	Brunt, Susan	FHO - Family Health Organization	
FHO - BALMORAL HEALTH GROUP (ROSEDALE)	Bukczynski, Jacob	FHO - Family Health Organization	
FHO - BALMORAL HEALTH GROUP (ROSEDALE)	Chen, Kelly	FHO - Family Health Organization	
FHO - BALMORAL HEALTH GROUP (ROSEDALE)	Gullane, Kira	FHO - Family Health Organization	
FHO - BALMORAL HEALTH GROUP (ROSEDALE)	Lafleche, Catherine	FHO - Family Health Organization	
FHO - BEDFORD	Culligan, Chris	FHO - Family Health Organization	
FHO - BEDFORD	Gupta, Vibhuti	FHO - Family Health Organization	
FHO - BEDFORD	Hasham, Aliya	FHO - Family Health Organization	
FHO - BEDFORD	Liu, Vivian	FHO - Family Health Organization	
FHO - BEDFORD	Marmoreo, Jean	FHO - Family Health Organization	
FHO - BEDFORD	McGee, Allison	FHO - Family Health Organization	
FHO - BEDFORD	Rubino, Mary	FHO - Family Health Organization	
FHO - BEDFORD (Bellair FP)	Karlinsky, Audrey	FHO - Family Health Organization	
FHO - BEDFORD (Bellair FP)	Khan, Nadira	FHO - Family Health Organization	
FHO - BEDFORD (Bellair FP)	Lee, Karen G.	FHO - Family Health Organization	
FHO - BEDFORD (Bellair FP)	Pearl, Monica	FHO - Family Health Organization	
FHO - BEDFORD (Bellair FP)	Rubin, Evelyn	FHO - Family Health Organization	
FHO - BEDFORD (Bellair FP)	Sathi, Nandini	FHO - Family Health Organization	
FHO - Bloor Park Medical	Mettle, Valerie	FHO - Family Health Organization	
FHO - Clinic at Christie Corner	Adelstein, Raquel	FHO - Family Health Organization	
FHO - Clinic at Christie Corner	Birdi, Ratika	FHO - Family Health Organization	
FHO - Clinic at Christie Corner	Bruni, Alison	FHO - Family Health Organization	
FHO - Clinic at Christie Corner	Hall, Alison	FHO - Family Health Organization	
FHO - Complete Care FHO	Caravaggio, Robert Joseph	FHO - Family Health Organization	
FHO - DOCTORS FHO	Borgono, Claudio	FHO - Family Health Organization	
FHO - DOCTORS FHO	Chu, Margaret	FHO - Family Health Organization	
FHO - DOCTORS FHO	Martins, Rui	FHO - Family Health Organization	
FHO - DOCTORS FHO	Masgoret, John	FHO - Family Health Organization	
FHO - DOCTORS FHO	Rodrigues, Susana	FHO - Family Health Organization	
FHO - DOCTORS FHO	Vera, Antonio	FHO - Family Health Organization	
FHO - DOCTORS FHO (BEHARRY MEDICAL CENTRE)	Beharry, Rajendra	FHO - Family Health Organization	
FHO - DOCTORS FHO (BEHARRY MEDICAL CENTRE)	Ding, Shiyang	FHO - Family Health Organization	
FHO - Downtown Toronto Doctors	Bedrossian, Diane	FHO - Family Health Organization	
FHO - Downtown Toronto Doctors	McNally, James	FHO - Family Health Organization	
FHO - Downtown Toronto Doctors	Rahim, Alya	FHO - Family Health Organization	

NAME OF GROUP/FHT *From dropdown list, select the name of the participating group or FHT, as registered with the Ministry or select 'solo fee-for-service' if not part of a group practice. If a group is not found in this list, add it to Other (column E).*	PHYSICIAN NAME (Last name, First name) *Providing the full list of your partner physicians will be critical for identifying which OHT attribution network the physician or PEM is affiliated and level of physician engagement*	PRACTICE MODEL *Select model type from dropdown list.. If 'other' is selected, please specify model type in Other .*	OTHER *If the listed physician or physician group works in a practice model that is not listed, please indicate the model type here. Note here if a FHT is a member but not its associated physician practice(s) and vice versa.*
FHO - HealthSource FHO	Canton, Toni	FHO - Family Health Organization	
FHO - HealthSource FHO	Chan, Bowen	FHO - Family Health Organization	
FHO - HealthSource FHO	Greenaway, Kate	FHO - Family Health Organization	
FHO - HealthSource FHO	Reich, Erin	FHO - Family Health Organization	
FHO - HealthSource FHO	Tisher, Carolyn	FHO - Family Health Organization	
FHO - King/Yonge Medical	Doyle, Sarah	FHO - Family Health Organization	
FHO - King/Yonge Medical	Faraj, Zein	FHO - Family Health Organization	
FHO - McKeown Medical Prof. Corp.	McKeown, Elizabeth	FHO - Family Health Organization	
FHO - MidTown FHO	Beattie, Doug	FHO - Family Health Organization	
FHO - MidTown FHO	Beattie, J. Douglas	FHO - Family Health Organization	
FHO - MidTown FHO	D'Angelo, Anthony	FHO - Family Health Organization	
FHO - MidTown FHO	Erenrich, Hedi	FHO - Family Health Organization	
FHO - MidTown FHO	Hogarth, Brooke	FHO - Family Health Organization	
FHO - MidTown FHO	Khoromi, Melina	FHO - Family Health Organization	
FHO - MidTown FHO	Lam, Jennifer	FHO - Family Health Organization	
FHO - MidTown FHO	Sachdeva, Preeti	FHO - Family Health Organization	
FHO - MidTown FHO	Satok, Peter	FHO - Family Health Organization	
FHO - MidTown FHO	Smith, Leah	FHO - Family Health Organization	
FHO - MidTown FHO	Zeldin, Susan	FHO - Family Health Organization	
FHO - MYFAMILYMD	Baker, Jason	FHO - Family Health Organization	
FHO - MYFAMILYMD	Goldman, Faye	FHO - Family Health Organization	
FHO - MYFAMILYMD	Hind, Sharon	FHO - Family Health Organization	
FHO - MYFAMILYMD	Lee, Stella	FHO - Family Health Organization	
FHO - MYFAMILYMD	Mathew, Silvy	FHO - Family Health Organization	
FHO - MYFAMILYMD	Morch, Sandra Ellen	FHO - Family Health Organization	
FHO - MYFAMILYMD	Wang, Richard	FHO - Family Health Organization	
FHO - ROSEDALE FHO	Abelsohn, Alan	FHO - Family Health Organization	
FHO - ROSEDALE FHO	Ang, Vivienne	FHO - Family Health Organization	
FHO - ROSEDALE FHO	Carleton, Amanda	FHO - Family Health Organization	
FHO - ROSEDALE FHO	Chan, Eugene	FHO - Family Health Organization	
FHO - ROSEDALE FHO	Davis, Jayne	FHO - Family Health Organization	
FHO - ROSEDALE FHO	Fried, Steven	FHO - Family Health Organization	
FHO - ROSEDALE FHO	Hudson, Stephanie	FHO - Family Health Organization	
FHO - ROSEDALE FHO	Lai, Garming	FHO - Family Health Organization	
FHO - ROSEDALE FHO	Sakuls, Peter	FHO - Family Health Organization	
FHO - SPADINA HEALTH CENTRE	Clark, Laura	FHO - Family Health Organization	
FHO - SPADINA HEALTH CENTRE	Freedman, Fred	FHO - Family Health Organization	
FHO - SPADINA HEALTH CENTRE	Ko, Karen	FHO - Family Health Organization	
FHO - SPADINA HEALTH CENTRE	Rossiter, Lea	FHO - Family Health Organization	
FHO - SPADINA HEALTH CENTRE	Tunzi, Christina	FHO - Family Health Organization	
FHO - Taddle Creek	Armstrong, Kristy	FHT - Family Health Team	
FHO - Taddle Creek	Barman, Mira	FHT - Family Health Team	
FHO - Taddle Creek	Biancucci, Christina	FHT - Family Health Team	
FHO - Taddle Creek	Davis, Bev	FHT - Family Health Team	
FHO - Taddle Creek	del Junco, Maria	FHT - Family Health Team	
FHO - Taddle Creek	Frasca, Erika	FHT - Family Health Team	
FHO - Taddle Creek	Hirsz, Abraham	FHT - Family Health Team	
FHO - Taddle Creek	Jackson, Beverley	FHT - Family Health Team	
FHO - Taddle Creek	Lemos, Vivienne	FHT - Family Health Team	
FHO - Taddle Creek	Machamer, Mary	FHT - Family Health Team	
FHO - Taddle Creek	Neuwstraten, Paula	FHT - Family Health Team	
FHO - Taddle Creek	Shaw, Sarah	FHT - Family Health Team	
FHO - Taddle Creek	Sugiyama, Jim	FHT - Family Health Team	
FHO - Taddle Creek	Vainberg, Mitch	FHT - Family Health Team	
FHO - Taddle Creek	Valentinis, Alissia	FHT - Family Health Team	
FHO - Taddle Creek	Yu, Jessica	FHT - Family Health Team	
FHO - WELCARE	Batra, Poonam	FHO - Family Health Organization	
FHO - WELCARE	Fried, Vera	FHO - Family Health Organization	
FHO - WELCARE	Killorn, Katie	FHO - Family Health Organization	
FHO - WELCARE	Kuruganty, Saila	FHO - Family Health Organization	
FHO - WELCARE	McNally, Catherine	FHO - Family Health Organization	
FHO - WELCARE	Ng, Jennifer	FHO - Family Health Organization	
FHO - WELCARE	Stone, Tanya	FHO - Family Health Organization	
FHO - YORKVILLE MEDICAL	Fiala, Jindrich	FHO - Family Health Organization	
FHO - YORKVILLE MEDICAL	Fiala, Katrina	FHO - Family Health Organization	
FHO - YORKVILLE MEDICAL	Grossman, Rachelle	FHO - Family Health Organization	
FHO - YORKVILLE MEDICAL	McLean, Shelley	FHO - Family Health Organization	
FHO - YORKVILLE MEDICAL	Philp, Lorraine	FHO - Family Health Organization	
FHT - Mount Sinai Hospital Academic FHT	Bearss, Erin	FHT - Family Health Team	Plus 2NP's (Sheena Luck & Rebecca Casas)
FHT - Mount Sinai Hospital Academic FHT	Biringer, Anne	FHT - Family Health Team	
FHT - Mount Sinai Hospital Academic FHT	Carroll, June	FHT - Family Health Team	
FHT - Mount Sinai Hospital Academic FHT	Forte, Milena	FHT - Family Health Team	
FHT - Mount Sinai Hospital Academic FHT	Kolker, Sabrina	FHT - Family Health Team	
FHT - Mount Sinai Hospital Academic FHT	Loganathan, Mayura	FHT - Family Health Team	
FHT - Mount Sinai Hospital Academic FHT	McIssac, Warren	FHT - Family Health Team	
FHT - Mount Sinai Hospital Academic FHT	Morson, Natalie	FHT - Family Health Team	
FHT - Mount Sinai Hospital Academic FHT	Naimer, Michelle	FHT - Family Health Team	
FHT - Mount Sinai Hospital Academic FHT	Nutik, Melissa	FHT - Family Health Team	
FHT - Mount Sinai Hospital Academic FHT	Tannenbaum, David	FHT - Family Health Team	
FHT - Mount Sinai Hospital Academic FHT	Walji, Sakina	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Akhtar, Sabrina	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Bloom, Jeff	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Crampton, Noah	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Esho, Dave	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Fleming, Sarah	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Francesco, Leanza	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Ji, Catherine	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Kaasa, Ben	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Kwong, Jeff	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Lam, Rob	FHT - Family Health Team	

NAME OF GROUP/FHT *From dropdown list, select the name of the participating group or FHT, as registered with the Ministry or select 'solo fee-for-service' if not part of a group practice. If a group is not found in this list, add it to Other (column E).*	PHYSICIAN NAME (Last name, First name) *Providing the full list of your partner physicians will be critical for identifying which OHT attribution network the physician or PEM is affiliated and level of physican engagement*	PRACTICE MODEL *Select model type from dropdown list.. If 'other' is selected, please specify model type in Other .*	OTHER *If the listed physician or physician group works in a practice model that is not listed, please indicate the model type here. Note here if a FHT is a member but not its associated physician practice(s) and vice versa.*
FHT - Toronto Western Hospital - Bathurst Site	Lemieux, Camille	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Mirchandani, Natasha	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Mizdrak, Nikolina	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Moaveni, Azi	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Oandasan, Ivy	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Peters, Rachel	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Reid, Sarah	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Schenker, Carly	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Singwi, Amita	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Sodhi, Sumeet	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Sparrow, Andrew	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Stubbs, Barbara	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Toubassi, Diana	FHT - Family Health Team	
FHT - Toronto Western Hospital - Bathurst Site	Tu, Karen	FHT - Family Health Team	
FHT - Toronto Western Hospital - Garrison Creek Site	Adegbite, Duate	FHT - Family Health Team	2 NPs (Allison Mann & Jessica Conner who is covering Christine Bottomley's maternity leave)
FHT - Toronto Western Hospital - Garrison Creek Site	Basma, Sarah (locum for Yvonne Kwok)	FHT - Family Health Team	
FHT - Toronto Western Hospital - Garrison Creek Site	Bourgeois, Sophie (covering Sarah Burns' maternity leave)	FHT - Family Health Team	
FHT - Toronto Western Hospital - Garrison Creek Site	Bricks, Corey	FHT - Family Health Team	
FHT - Toronto Western Hospital - Garrison Creek Site	Deria, Mariam	FHT - Family Health Team	
FHT - Toronto Western Hospital - Garrison Creek Site	Lo, Amanda	FHT - Family Health Team	
FHT - Toronto Western Hospital - Garrison Creek Site	Mahmoud, Sarah	FHT - Family Health Team	
FHT - Toronto Western Hospital - Garrison Creek Site	O'Sullivan, Rory	FHT - Family Health Team	
FHT - Toronto Western Hospital - Garrison Creek Site	Payne, Lauren	FHT - Family Health Team	
FHT - Toronto Western Hospital - Garrison Creek Site	Pivnick, Lucie (locum for Jennifer Sy)	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Agarwal, Payal	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Anta, Viola	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Bhattacharyya, Onil	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Biswas, Tuhina	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Chen, Betty	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	deSouza, Melissa	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Dmytryshyn, Rob	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Dunn, Sheila	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Feldman, Kymm	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Grundland, Batya	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Heisey, Ruth	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Holzapfel, Stephen	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Hsiang, Diana	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Ivers, Noah	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Kim, Susie	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Kitai, Carol	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Levitan, Debbie	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Lichtblau, Brad	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Maker, Dara	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Martin, Danielle	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Myers, Jesse	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Nutt, Sam	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Patel, Nikita	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Pimlott, Nick	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Rambihar, Vanessa	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Schermbrucker, Jonah	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Shachar, Orli	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Sheps, Jordana	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Shukla, Hemen	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Spithoff, Sheryl	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Stratton, Laura	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Whitehead, Cynthia	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Wong, Karen	FHT - Family Health Team	
FHT - Women's College Academic Family Health Team	Wu, Melinda	FHT - Family Health Team	
HIV - MAPLE LEAF MEDICAL CLINIC	Acsai, Megan		HIV Clinic
HIV - MAPLE LEAF MEDICAL CLINIC	Armstrong, Ian		HIV Clinic
HIV - MAPLE LEAF MEDICAL CLINIC	Barrie, William		HIV Clinic
HIV - MAPLE LEAF MEDICAL CLINIC	Chang, Benny		HIV Clinic
HIV - MAPLE LEAF MEDICAL CLINIC	Crouzat, Frederic		HIV Clinic
HIV - MAPLE LEAF MEDICAL CLINIC	Giolma, Kevin		HIV Clinic
HIV - MAPLE LEAF MEDICAL CLINIC	Gordon Liu		HIV Clinic
HIV - MAPLE LEAF MEDICAL CLINIC	Kovacs, Colin		HIV Clinic
HIV - MAPLE LEAF MEDICAL CLINIC	MacKinnon, Amelia		HIV Clinic
OTHER - HEALTHCARE365	Kohut, Vera		1 Physician, 1 NP, 2 Nurses & tech team
OTHER - INNER CITY HEALTH ASSOCIATES	Bond, Andrew		2NP's Anna Marquez & Susan Grabias
PEM - Carlton Medical Group HIV AFP	Brunetta, Jason	AFP - HIV PRIMARY CARE	
PEM - Carlton Medical Group HIV AFP	Knox, David	AFP - HIV PRIMARY CARE	
PEM - Carlton Medical Group HIV AFP	Merkley, Barry	AFP - HIV PRIMARY CARE	
PEM - Carlton Medical Group HIV AFP	Smith, Graham	AFP - HIV PRIMARY CARE	
PEM - COMPLETE CARE FHO	Chada, Reena	FHO - Family health organization	
PEM - COMPLETE CARE FHO	Chuen, Luan	FHO - Family health organization	
PEM - COMPLETE CARE FHO	Malik, Puja	FHO - Family health organization	
PEM - COMPLETE CARE FHO	Sood, Danesh	FHO - Family health organization	

2.1.2 Home and Community Care and Secondary Care Partners

NAME OF ORGANIZATION *Provide the legal name of the member organization*	TYPE OF ORGANIZATION *Select type from dropdown list, if 'other' please specify type in column C*	OTHER ORGANIZATION TYPE	FACILITY SITE(S) *(For all of your hospital and Community Health Center partners please identify all of the specific sites that are partners ex. Quinte Healthcare, Belleville General Hospital site)*
Access Alliance Multicultural Health and Community Services	COMMUNITY HEALTH CENTRES		Downtown College Site (Main Site for MWT-OHT); AccessPoint on Danforth; AccessPoint on Jane
Alpha House Inc.	MENTAL HEALTH AND ADDICTION ORGANIZATIONS	Residential Addictions Program	
Bellwoods Centres for Community Living Inc.	COMMUNITY SUPPORT SERVICES	Home Care	
Breakaway Addiction Services	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
CAMH	HOSPITALS		Queen Street Site; College Street site; Ursula Franklin Site
Centre Francophone du Grand Toronto	COMMUNITY HEALTH CENTRES		Head Office - Downtown Toronto
COTA Health (Cota)	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Davenport-Perth Neighbourhood and Community Health Centre	COMMUNITY HEALTH CENTRES	Neighbhourhood Health Centre	Heath Centre, Neighbourhood Centre; Edgewest Healthcare for Youth
Eden Community Homes	MENTAL HEALTH AND ADDICTION ORGANIZATIONS	Home Care	
Family Service Toronto	COMMUNITY SUPPORT SERVICES		
Fife House	COMMUNITY SUPPORT SERVICES	Home Care	
George Herman House	MENTAL HEALTH AND ADDICTION ORGANIZATIONS	Home Care	*Please note: Endorsement forthcoming.*
Gerstein Crisis Centre	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Habitat Services - Mental Health Program Services of Metropolitan Toronto	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Inner City Family Health Team	OTHER, PLEASE SPECIFY	Family Health Team	
Inner City Health Associates	OTHER, PLEASE SPECIFY	Primary Care	
Jean Tweed	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Kensington Health	LONG-TERM CARE HOMES	Independent Health Facility	
LHIN Home and Community Care	OTHER, PLEASE SPECIFY	Home Care	
LOFT Community Services	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Mount Sinai Academic Family Health Team	OTHER, PLEASE SPECIFY	Family Health Team	
Parkdale Activity Recreation Centre	COMMUNITY SUPPORT SERVICES		
Parkdale Queen West Community Health Centre	COMMUNITY HEALTH CENTRES		Parkdale Site; Queen West Site; Satellite Office Site
Planned Parenthood Toronto	COMMUNITY HEALTH CENTRES		Planned Parenthood Toronto (only site)
Progress Place Rehabilitation Centre (MetropolitanToronto) Inc.	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Reconnect Community Health Services	COMMUNITY SUPPORT SERVICES		
Renascent Fellowship	MENTAL HEALTH AND ADDICTION ORGANIZATIONS	Home Care	
Sinai Health System	HOSPITALS	Home Care	Mount Sinai Hospital; Bridgepoint Active Healthcare; Lunenfeld-Tanenbaum Research Institute
Society of Sharing Inner-city Volunteers	COMMUNITY SUPPORT SERVICES	Home Care	
St. Felix	COMMUNITY SUPPORT SERVICES		*Please note: Endorsement forthcoming.*
St. Michael's Homes	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Stella's Place	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Strides Support Services Toronto	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Surrey Place	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
Taddle Creek Family Health Team	OTHER, PLEASE SPECIFY	Family Health Team	
The Neighbourhood Group Community Services	COMMUNITY SUPPORT SERVICES		
The Salvation Army Toronto Grace Health Centre	OTHER, PLEASE SPECIFY	Complex Continuing Care, Post Acute Care Rehabilitation and Palliative Care	
The Toronto Mental Health and Addictions Access Point (The Access Point)	MENTAL HEALTH AND ADDICTION ORGANIZATIONS	The Access Point is a Toronto North Support Services program and therefore the board chair endorsement for TNSS covers both organizations. The MWT-OHT recognizes each organization as an endorsed member.	
Toronto Central LHIN	OTHER, PLEASE SPECIFY	LHIN	
Toronto North Support Services	COMMUNITY SUPPORT SERVICES		
Toronto Public Health	OTHER, PLEASE SPECIFY	Public Health	
Toronto Western Family Health Team	OTHER, PLEASE SPECIFY	Family Health Team	
Transition House Inc.	MENTAL HEALTH AND ADDICTION ORGANIZATIONS		
University Health Network (UHN)	HOSPITALS		Princess Margaret Cancer Centre; Toronto General Hospital; Toronto Western Hospital; Toronto Rehab - Bickle Centre; Toronto Rehab – Lakeside; Toronto Rehab - Lyndhurst Centre; Toronto; Rehab - Rumsey Centre; Toronto Rehab - University Centre; Michener Institute
UHN, OpenLab	OTHER, PLEASE SPECIFY	Co Design Consultants	
Waterfront NC	COMMUNITY SUPPORT SERVICES		*Please note: Endorsement forthcoming.*
West Neighborhood House	COMMUNITY SUPPORT SERVICES	Community Mental Health and Addictions, Home Care Subcontractor (VHA as Contract Holder)	
Women's College Academic Family Health Team	OTHER, PLEASE SPECIFY	Family Health Team	
Women's College Hospital	HOSPITALS		Women's College Hospital (one site)
Working for Change	OTHER, PLEASE SPECIFY	Patient Advisors	
Yonge Street Mission	COMMUNITY SUPPORT SERVICES	Community Support Services, which include a free Homeless Youth Focused Dental & Health Clinic	

2.2 Confirming Other Team Partnerships

If members of your team have signed on or otherwise made a commitment to work with other teams, please identify the partners below:

Team Member	Other Affiliated Team(s)	Reason for affiliation
	List the other teams that the member has signed on to or agreed to work with	*Provide a rationale for why the member chose to affiliate itself with multiple teams (i.e. meets exceptions identified previously e.g. specialized service provided such as mental health and additions services)*
Access Alliance Multicultural Health and Community Services	East Toronto OHT; West Toronto OHT	South Riverdale is the sector lead (CHC) in the East and we have a collaboration as CHCs to work together.
Bellwoods Centres for Community Living Inc.	East Toronto Health Partners, West Toronto OHT, North Toronto OHT, Downtown East Toronto OHT	Attendant housing across multiple geographies that span Toronto and therefore need to be participate in all Toronto OHTs.
COTA Health (Cota)	North Western Toronto OHT; North York Toronto Health Partners OHTs; East Toronto Health Partners OHT; West Toronto OHT, Downtown East Toronto OHT and Scarborough OHT	COTA Health (Cota) provides a wide range of services to people living with mental health and cognitive challenges across the city of Toronto. We provide service to people living with mental health challenges, concurrent disorders, geriatric mental health conditions, acquired brain injuries, developmental disabilities, dual diagnoses and the experience of homelessness. Our services include, but are not limited to, case management, over 500 units of supportive housing, Streets to Homes Follow-Up Services, a Mobile Crisis Intervention Team (MCIT) Follow-Up Service, short-term residential crisis beds, and mental health court and release planning services. Our services are delivered via the generous funding support we receive from Central LHIN, Toronto Central LHIN, MOHLTC, MCCSS, the City of Toronto and through purchase of service contracts we hold with other health care organizations such as St. Michael's Hospital, North York General Hospital and Scarborough Centre for Health Communities.Given the depth and breadth of our service offerings across the city, we have organized our programs in such a way that they align very well with Ontario Health Teams that are emerging across Toronto. In addition, we have organized our leadership structure to enable our active participation in and contributions to several OHT planning and implementation tables.
Family Service Toronto	Downtown East Toronto OHT; monitoring East Toronto OHT and North Toronto OHT	Family Service Toronto is a city-wide organization that provides mental health supports to all people who live or work in Toronto.
Fife House	Downtown East Toronto OHT	Meets expectations as a specialized service provider - housing/homelessness and mental health and additions service provider. Multiple sites across both DET and MWT.
Habitat Services - Mental Health Program Services of Metropolitan Toronto	West Toronto OHT	Housing services across all of Toronto so could technically join 6 teams but don't want to spread themselves too thin.
Inner City Family Health Team	Downtown East Toronto Team, Scarborough Team	Inner City Family Health Team serves homeless and previously homeless individuals in partnership with our physician group Inner City Health Associates. While our main clinic is in downtown Toronto, we provide the clinical supports at our Scarborough Village Residence for former Seaton House residents, as well as in the Mid-West at a supportive housing program managed by Madison Community Services. In Scarborough, in addition, we were the lead agency partnering with the City of Toronto running the Scarborough Isolation Site, and we have a planned partnership in the Mid-West with the City of Toronto at another shelter location at Bloor and Dundas St. W. Because our population is extremely transient, our patients at our Family Health Team come from all parts of Toronto, but particularly from the Mid-West through Downtown East and into Scarborough. Therefore, Inner City Family Health Team, is on planning tables on all three Ontario Health Teams, along with our physician partner, Inner City Health Associates. With already obtained Board approval, we are hoping to be included in all three Ontario Health Teams.
Inner City Health Associates	Downtown East OHT (partner); Scarborough OHT (collaborator); East Toronto Health Partners (collaborator)	ICHA provides specialized clinical services(primary care, psychiatry, specialist care and palliative care) to people experiencing homelessness across the city of Toronto. Our services are provided at over 55 different sites which span different OHT geographies.
LOFT Community Services	North Toronto OHT; North Western Toronto OHT; North York Toronto Health Partners; Eastern York Region North Durham OHT; Southlake Community OHT; Downtown East Toronto OHT	LOFT Community Services provides supportive housing, community support and outreach, case management, care coordination and system navigation services to over 5,800 people in multiple regions across Southern Ontario. Given LOFT's regional efforts, Ontario Health has advised that LOFT can be affiliated with multiple OHTs.
Mount Sinai Academic Family Health Team	York Region	Vaughn Site is located within the referral network of the York Region OHT.
PARC (Parkdale Activity - Recreation Centre)	West Toronto OHT	Specific partnerships with Unity/St.Jo's and other health providers that are part of the West Toronto OHT.
Planned Parenthood Toronto	West Toronto OHT; Mid East Toronto OHT; East Toronto OHT; North Toronto OHT	Planned Parenthood will be looking at ways that they can support all 5 Toronto based OHTs as we serve youth that are facing barriers to access from all regions of Toronto.
Progress Place Rehabilitation Centre (MetropolitanToronto) Inc.	Downtown East Toronto OHT; West Toronto OHT	**East:** Head office is located in the DTE, it is an internatonal model called Clubhouse, a one of a kind program in Toronto. We have clients we call members that attend from all over the GTA including Peel, Ajax, Pickering etc. we are the lead for a Senior Mental Health Day Program in St. James Town and we offer. We also have a peer support Warm Line that provides support to people that are stressed, lonely and isolataed from 8pm to midnight 7 days a week. This service is offered to anyone who calls, texts or emails. **West:** We oversee a program called The Community Place Hub in the Weston and Lawrence area, it is a drop in for all ages with a focus on mental health supports along with health access. This is accomplishe by collaborating with 20 other service providers cal The Weston Mount Dennis Service Provider Network and Progress Place is the lead for the network. In addtion to the above we have over 200 of our members that attend Progress Place living in the mid-west Toronto area. We have a great partnership with Toronto Western Hospital where we offer a peer support program called Double Recovery this is a support for people with mental health and addicitions issues. We have also been working at engaging people that "hang out" in the Atrium of the Toronto Western site and trying to connect them with needed services and programs such as Progress Place.
Reconnect Community Health Services	West Toronto OHT	Serve clients in both geographies.
Renascent Fellowship	East Toronto Health Partners	Residential addictions treatments service are regional/provincial resource.
St. Michael's Homes	East Toronto Health Partners; Downtown East OHT; West Toronto OHT	St. Michael's Homes serves men with substance use problems from across the province and women and men with mental health in Toronto. As our Treatment and Housing Programs serve individuals from across Ontario, with 31% from outside the Toronto area, we are a specialized addiction service serving the patients of multiple OHTs. In order to respond effectively to the OHTs where the greatest number of our clients originate, we are focusing our OHT work within the four OHTs listed in Column B. Having clients from a broad geography, has led us to build and establish partnerships with health service organizations across Toronto, especially in these four OHTs.
The Neighbourhood Group Community Services	East Toronto OHT; Downtown East Toronto OHT	TNG is a merger of three organizations (Central Neighbourhood House, Neighbourhood Link Support Services and St Stephen's House Community Services), having their own "head offices" located in each of the three OHTs of which we are engaged partners. We provide Homelessness, Mental Health and Addictions services, as well as Home and Community Care services across all three OHTs
The Salvation Army Toronto Grace Health Centre	Downtown East Toronto OHT	The Salvation Army Toronto Grace Health Centre (TSA TGHC) is involved in multiple OHTs as they serve the province. Specific to TCLHIN, TSA TGHC services all of TCLHIN region
Toronto North Support Services and The Toronto Mental Health and Addictions Access Point (The Access Point)	North York Toronto OHT (Core Partner), North Toronto OHT (Supporting Partner), Downtown East Toronto OHT (Involved)	In terms of other OHT's, TNSS a Core partner of the North York Toronto OHT and a supporting partner of the North Toronto OHT. The reason we feel that we should also participate in the MWT OHT is that we have a number of services in the downtown core that are meant to serve those who have MH&A issues and experience homelessness. We look forward to assisting the MWT OHT to fulfill it's year 1 projects
Yonge Street Mission	Mid-East Toronto OHT	The Yonge Street Mission is a multi-service, social development agenday focused on supporting three distinct and vulnerable populations. We have a dedicated street-involved hub located in the Mid-West, which is specialized to provide wrap around care - including primary and auxiliary health services - to homeless youth. In the Mid-East, we offer a campus of services to the Regent Park and surrounding neighbourhoods, which addresses the social determinents of health, to provide care to the whole person, including mental health counselling and case management.

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

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

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

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Please see Supplementary Tables 2.1.1, 2.1.2 and 2.2 attached above.

2.3

1. History of working relationships in the Mid-West

There is a strong and longstanding history of cross-sectoral collaboration within the MWT region. Our OHT will build on the strong foundation of coordination and transparency between partners, formed either organically within sectors, or through deliberate formal initiatives including the Mid-West Collaborative, Primary and Community Care Coordinating Committee and HealthLinks. All partners share a vision to address the complex needs of our uniquely urban community.

The MWT partners can demonstrate countless examples of collaboration to advance integrated care, shared clinical accountability, and population health (see Appendix 4). The following are a few of the marquee examples of such collaboration:

• SCOPE (Seamless Care Optimizing the Patient Experience) and SPiN (Solo Physicians in Need): These are two separate primary care integration initiatives that share a common theme of providing seamless, coordinated access to specialist care and community support services to primary care providers and their patients. These initiatives originated in MWT as partnerships between primary care, acute care, and community care sectors, and have scaled and spread across Toronto and beyond to other provincial regions. What they share is the creation of a virtual interdisciplinary team around the patient. These programs will function as the scaffolding of the OHT and will be scaled to provide barrier-free, 24/7 care coordination for all people attributed to the MWT-OHT.

• Short-term Transitional (STTCM) Care Model: This system of care was developed in response to patients' concerns about problematic transitions between care providers. The initiative involves close partnership between 16 community health service providers (including many in the Mid-West such as LOFT, UHN, WNH, Bellwoods, Toronto Central LHIN and Reconnect) all working toward reduction in ALC days through provision of over 200 Reintegration Care Units (RCUs) (bedded spaces) across 12 locations in Toronto. The STTCM Care Model demonstrates the value of improved transitions for health outcomes in our population. The MWT-OHT is committed to building on the principles of this and similar programs to improve care pathways throughout our system.

• ICHA and TCAT: Partners in the Mid-West Toronto have learned the importance of non-traditional approaches to care. For example, models that bring care directly to the patients, such as the Inner City Health Associates (ICHA) model, which brings primary care, psychiatry, and palliative care to patients in shelters, drop-ins and respite sites across the city rather than expecting these structurally vulnerable patients to come to them. Another example is the Toronto Community Addiction Team (TCAT) that provides mobile intensive case management for people with complex substance use challenges who are high users of emergency department and withdrawal management services.

As demonstrated above, these partnerships are truly cross-sectoral; are formed around the core needs of the population served as identified by our patients and caregivers; and are built on a deep understanding of how our unique population lives, interacts and accesses healthcare.

1. Partnership during COVID-19, how can they be leveraged for wave two and for year 1 priority:

Never has the need for collaboration and support been greater than during the COVID-19 pandemic. Appreciating the uncertain and often devastating nature of COVID-19, the same partnership principles – involving all sectors, understanding patient core needs and respecting population care access patterns – applied to the response efforts. The strong history of collaboration, powered by foundational trust, allowed for swifter, more thoughtful reactions by partners in the Mid-West.

The following initiatives showcase some examples of partner collaboration within MWT. These examples are broader reaching than the MWT-OHT, but act as blueprints of collaboration that will be foundational for the development of the OHT.

• The Homeless and Underhoused: This COVID-19 response effort involved collaboration between Community Based Agencies (Parkdale Queen West CHC,

Toronto North Support Services, Breakaway Addictions, COTA, The Neighbourhood Group) Primary Care Providers (Inner City Health Associates, Inner City Family Health Team) and Hospital (University Health Network), through multidisciplinary teams (nursing, harm reduction, addiction medicine, peer support, physician care) in order to optimize safety and care to one of our most structurally vulnerable populations. The early work of this group was the creation of the hotel recovery sites, which provided an opportunity for 1,000 homeless and underhoused individuals to isolate safely.

Concurrently, this team provided mobile support to 100% of the drop-ins and shelters across the city (all challenged by social distancing guidelines) and completed over 5,500 COVID-19 tests. Thanks to a collaboration with Anishnawbe Health Centre, the mobile testing program was also able to provide culturally safe testing and care to individuals who identify as Indigenous.

These initiatives demonstrate the ongoing need for an interdisciplinary, medical and social care approach due to the complexity of the population – COVID-19 is only one element, while mental health, substance use, homelessness, isolation, and racialization are also crucial determinants. Work with clients experiencing homelessness will continue in the form of mobile support and testing – partnering with community to reach structurally vulnerable populations and to integrate influenza vaccinations.

• Frail Seniors in Long-Term Care: Building off the relationships and principles previously established through the LTC+ Program and academic expertise in the area of older adults, Hospitals and Long-Term Care Homes such as Women's College Hospital and Kensington Health, were able to provide a collaborative COVID-19 response through a Hospital Resource Partnership. The partnership addressed the gaps and needs of LTC homes in order to employ public health recommendations to keep residents, staff and family safe, educated and assured, while also demonstrating the value of virtual care teams to provide 24/7 virtual in-home care and support and limit unnecessary transfers to the ED. The success of the collaboration is largely attributed to the respect for each organization's autonomy and philosophies of care while sharing a common goal of addressing core resident needs.

• Community Mental Health & Addictions: Leadership from CAMH and LOFT chaired a Toronto Region COVID-19 response table. While initially preparing to respond to a PPE challenge, the hospital-community collaboration learned (by listening to staff and patient advisors) that there was a gap and opportunity to become a central resource for education, stabilization and communication. These three core resources were offered to all MHA providers in the community with an enhanced focus on congregate settings. This partnership model is continuing in preparation for a potential second

wave of COVID-19 and has demonstrated the value of a central source of support for small agencies on an on-going basis.

3.0. Leveraging Lessons Learned from COVID-19

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

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

Max Word Count: 500

The COVID-19 pandemic has furthered the resolve of MWT primary, acute, and community care providers to bring services to where people are forced to shelter. For maximum effectiveness, all organizations and solo providers have expanded or pivoted their services to meet the needs of the community. Examples of these creative augmentations are outlined below, including commentary on the intention to continue through a potential second wave and scale throughout the MWT-OHT in Year 1:

• Primary Care: The COVID-19 pandemic has created unprecedented barriers between patients and providers. Patients are unable to visit their family doctors for fear of putting themselves or others at risk, and some solo or dyad practices are unable to remain open. To continue to attend to the medical needs of the entire population, primary care providers have adopted virtual care options, ranging from telephone, video conference to email. Additionally, the COVIDCARE@HOME initiative, co-led by Women's College and Sinai Health System, has partnered with community providers to offer virtual and in-person consultations where necessary. As referenced in section 4.2, virtual primary care capacity will continue to grow within MWT, and we will look for opportunities to scale and standardize through the OHT. The MWT-OHT will also look to increase LTC+ (or equivalent) support to all solo physicians who provide LTC and home care services.

• Home Care: To allow for physical distancing while continuing to support frail seniors to live at home, the West Neighbourhood House pivoted to an "Adult Day Program (ADP) at Home". Key services of this program include virtual connection at home (patients provided with iPad); in-home Personal Support Worker (PSW) activation, stimulation and fitness, all with the option for family participation. Additionally, security checks have ensured that frail seniors living on their own or without adequate caregiver support have increased surveillance at this time. To continue to provide specialist attention and therapy to this population, partners in

the MWT-OHT recognize the value of equipping PSWs with additional virtual care technology and education. As such, in Year 1, the MWT-OHT plans to support enhanced training to PSWs on virtual care thereby reducing the number of incremental providers needing to physically enter the home.

• Community and Mental Health Care: The pandemic has tested the ability of Community and Mental Health providers to address the immediate needs of their populations. Building on decades of thoughtful adaptation in service delivery, these organizations have done whatever it takes to stay connected with their patients. For example, all Community Health Centres have remained open since March 2020, providing a mix of both in-person and virtual service depending on individual risk factors. Other organizations, such as Stella's Place for Young Adult Mental Health, initially converted all group and one-to-one programming to virtual. After several months, Stella's Place conducted interviews and service co-design to determine which programs were as effective virtually (ex. Dialectical Behavioural Therapy) and those which can only thrive in person. This balanced approach to service offerings is historically prevalent in MWT, and only made possible by co-designing with people with lived experience.
The partners of the MWT-OHT have expressed their commitment to enhancing or adapting their services in whatever way meets the needs of the population, especially the most structurally vulnerable. A standing item on All Partner meeting agendas in Year 1 will be "COVID-19 Response Gaps and Services to Address".

4.0. How will you transform care?

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

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

- Number of people in hallway health care beds
- Percentage of Ontarians who had a virtual health care encounter in the last 12 months
- Percentage of Ontarians who digitally accessed their health information in the last 12 months
- 30-day inpatient readmission rate
- Rate of hospitalization for ambulatory care sensitive conditions
- Wait time for first home care service from community
- Frequent ED visits (4+ per year) for mental health and addictions
- Patient reported experience and outcome measures and provider experience measures (under development)
- ED physician initial assessment
- Median time to long-term care placement

4.1 Performance Measures

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

Population	Outcome measures	Performance Measures	Purpose/Rationale	Method of Collection/Calculation
Year 1 Priority Population: Homeless and Underhoused	Improved health status among the underhoused population; improved practical access to coordinated care for this population	1a. Homeless and Underhoused: Patient Reported Health Status	Respects the autonomy and individuality of the person and their care goals.	Confirm Y1 target population; Pre- and Post-Survey for self-reported health status, survey methodology to be developed with individuals with lived experience.
		1b. Homeless and Underhoused: % of Population Attached to Primary Care, Case Management, Mental Health and Substance Use Support	This Priority Population has below average attachment to Primary Care providers resulting in poorer health outcomes.	Confirm Y1 target population; Pre- and Post-Survey for Attachment to health services; In Y2 and beyond, MWT to survey 'meaningful attachment'; Survey methodology to be developed with individuals with lived experience.
Year 1 Priority Population:Frail Seniors	More frail seniors kept healthy at home; acute episodes for this population reduced through prevention	2. Frail Seniors: # of avoidable ED visits by residents of specific partner LTC homes	The goal of the Y1 initative for this Priority Population is to continue primary care provision in the Senior's preferred place of residence, and therefore avoid costly ED transfers.	ED visits for a few specific homes actively engaged with HRP and LTC+. Will monitor monthly using Intellihealth data for residents with ED visits to Toronto hospitals.
Year 1 Priority Population: Mental Health & Substance Use	Improved timeliness of care for people living with substance use challenges.	3. Mental Health and Substance Use: Wait times for residential and non-residential treatment following UHN Withdrawal Management Service	Wait time for treatment will reflect the efficiency in the overall pathway of substance use service as this is the part of the pathway with the biggest gap and therefore opportunity for relapse	For patients referred to treatment, the time between discharge from WMS and a) admission to residential treatment or b) first non-residential treatment session where that treatment occurs via a MWT-OHT treatment provider
Entire attributed population	Improved timeliness of coordinated care for primary care patients	4. Number of calls from Primary Care providers to SCOPE hub	Number of interactions between primary care provider partners and specialists using a virtual tool to communicate.	Data collected through the SCOPE program.

- Alternate level of care (ALC rate)
- Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
- Total health care expenditures
- Timely access to primary care
- Supporting long-term care and retirement homes, particularly in cases of a COVID-19 outbreak
- 7-day physician follow up post-discharge
- Hospital stay extended because the right home care services not ready
- Caregiver distress
- Time to inpatient bed
- Potentially avoidable emergency department visits for long-term care residents

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

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

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

Performance Measures	Purpose/Rationale	Method of Collection/Calculation
1. See previous page	for Supplementary Template.	
2.		
3.		
4.		
5.		

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

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

In the context of COVID-19, increasing the availability of digital health solutions, including

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

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Building on existing local digital capacities and leveraging regional and provincial resources available, the MWT-OHT will develop a digital health strategy to support our Year 1 priority populations, particularly in the mental health and addictions, long-term care, primary and community care sectors within the partnership. Aligned with the overarching goals of the MWT-OHT, we will also focus on developing a digital strategy that supports the removal of barriers for our structurally vulnerable populations such that existing health inequities are not reinforced through our digital health approaches.

Digital Health Utilization in Mid-West Toronto

A survey completed by our partners prior to the COVID-19 pandemic indicated that more than half of our partners offer virtual care services to patients and providers within the community. Existing capabilities include enabling provider to patient interaction, provider to provider communication, access to clinical documentation, and empowering patients to self-manage with access to their health information.

In response to the pandemic, partners increased adoption of virtual care tools to meet the diverse needs of our patients and providers. Examples include but not limited to:

•Equitable access – to enable vulnerable patients with access to virtual care, partners:
o provided private spaces for virtual visits;
o established innovative partnerships with internet service providers and libraries to provide devices and internet access to those otherwise without; and
o trained home care PSWs to support their frail senior patients to access virtual care in their homes.

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

• Primary care to patient interaction – the majority of primary care providers are offering virtual care for patients to safely and remotely access care at their home or in the community. Common tools utilized include telephone and OTN-certified eVisit tools.
• Mental health and Addictions provider to patient interaction - 23 survey respondents indicated that they provide virtual care to their patients commonly through telephone and Zoom.
• Long-term care to acute care provider interaction – through the LTC+ Program, providers at 13 Long-term Care and Retirement Homes have 24/7 access to acute specialists for urgent support or consultation on resident care. Some homes also provide remote access to their primary care providers. Common tools used include telephone, OTN-certified eVisit tools and Zoom/MS Teams.

Providing Virtual and Digitally Enabled Care in the Mid-West Toronto OHT
Beyond the pandemic, we look to continue to build on existing virtual care capacities by improving the quality of interactions, establishing supports and capacity for staff and exploring opportunities to have tools available across partners where appropriate.

Our virtual care journey continues to evolve and adapt to the changing environment. We continue to collaborate towards setting Year 1 priorities shaped by our collective learnings on developing partnerships, enabling equitable and sustainable access to care for our community. In Year 1, we will focus on establishing a Digital Health Program with governance to guide prioritization of initiatives aligned with serving the needs of our population, as well as supporting the provincial digital health priorities. Our program will comprise of patients, caregivers, and service providers collaborating on strategies to seamlessly and efficiently deliver quality care across the continuum, leverage existing digital solutions where appropriate and innovating where needed. We will also explore sustainable strategies to provide equitable patient access to devices (e.g. computers, phones, and remote patient monitoring devices), internet connection, confidential space, and technical supports.

In the future, we aspire towards a digitally-enabled OHT by equipping our health services providers with access to the information they need, when they need it and technologies to de

Contact for digital health *Please indicate an individual who will serve as the single point of contact who will be responsible for leading implementation of digital health activities for your team*	Name: Alexis Villa
	Title: Program Director
	Organization: University Health Network (UHN) Connected Care
	Email: Alexis.Villa@uhn.ca
	Phone:

4.3. How will you address diverse population health needs?

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

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

4.3.1. How will you work with Indigenous populations?

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

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

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

Max word count: 1000

The Mid-West Toronto Ontario Health Team would like to firstly acknowledge that our health care and community services are provided upon the traditional lands of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples and is now home to many diverse First Nations, Inuit and Métis peoples.

With gratitude we also acknowledge that the settler population has been able to benefit from this beautiful land and we are grateful for the opportunity to work with communities across this territory.

As the partners of the MWT-OHT redesign care to meet the needs of the diverse populations we serve, and specifically address inequities in care and health outcomes, we will look to our Indigenous colleagues for guidance and continue to be allies working towards breaking down the barriers that continue to violate Indigenous communities.

This allyship will seek to align with the important work and pursuit of any sovereignty and self-government discussions with provincial and national leadership from Indigenous communities. We recognize and honour the importance of autonomy and self-governance of our Indigenous partners and that decision-making regarding health care delivery for Indigenous People belongs in their hands. As well, we will be mindful of and attempt to encompass key recommendations emerging from Canada's Truth and Reconciliation Commission calls to action and the United Nations Declaration on the Rights of Indigenous Peoples. These would include fostering mutual respect between Indigenous and non-Indigenous partners and taking direction from our Indigenous colleagues to build a health care system that fosters dignity, peace and prosperity for Indigenous People.

As we focus on improving the care of our Year 1 populations, people living with mental health and substance use challenges, fragile elderly and the homeless and underhoused, we will endeavor to include Indigenous People in any co-design process, but always with respect and in partnership, relying on our Indigenous colleagues to manage any outreach to their own communities.

We recognize that this work has been ongoing for many years and acknowledge that a specific reciprocal relationship with the MWT-OHT as a new entity is a relationship in development. Our primary goal in Year 1 and going forward will be to focus on strengthening this relationship so there is mutual trust and transparent communication and collaboration. This is the fundamental building block to developing a true partnership. Recognizing and learning about cultural traditions and healing practices from our partners and how these could be better incorporated into our health care system will be a step in the direction of understanding the current gaps that exist for Indigenous People.

The MWT-OHT is committed to aligning with the vision of Anishnawbe Health Centre and its plans for an Indigenous Ontario Health Team, while also being committed to working as allies to help advance agendas that help the Indigenous People. As a

collective of non-Indigenous led organizations, we are committed to understanding how the colonial history influences the patient and provider relationship today, including the deleterious and trans-generational effects of the residential school system, and training our teams to provide culturally safer services to Indigenous patients and clients who choose to seek care from our services providers. We recognize and respect the unique identities and diversity of Indigenous peoples and the need for a distinct approach to anti-racism and equity measures for Indigenous peoples.

We will be consistent in deferring to their wisdom and experience in engaging their communities and their right for self-determination and being involved in decisions that affect them. We would take our direction from the Anishnawbe Indigenous Ontario Health Team for any actions including but not limited to:

• Supporting culturally-appropriate education of health care providers to deliver non-stigmatizing trauma-informed care
• Helping to broker hospital policies that embrace the healing traditions of Indigenous People
• Helping to inform data collection that more accurately reflects Indigenous patient experience and outcomes
• Co-designing and implementing tools and resources that are more friendly to the Indigenous population such as assessments, quality improvement projects, case management processes etc.

We will work side-by-side with Anishnawbe Health Toronto to help define what success truly looks like in improving health care such that it becomes life-affirming for Indigenous People. Any recommendations regarding the health of Indigenous People would defer to the traditional talking circle of Indigenous colleagues to ensure decisions are informed and Indigenous driven.

We appreciate that this work cannot be rushed, and we will engage and support when requested.

4.3.2. How will you work with Francophone populations?

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

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

to expand or modify these activities or otherwise specifically seek to address Francophone health or health care needs in Year 1 or longer-term.

Max word count: 500

Toronto is home to a rich diversity of Francophone communities – a population that, as a result of immigration, is projected to increase from 3 per cent to 4.7 per cent of the total population by 2028[1]. This rich diversity translates into complex and varied health needs and a significant need for better connection between Francophone patients and health care services provided in the official language of their choice. There are 8,530 Francophones in MWT; a population that is increasingly diverse and multicultural with one in three Francophones identifying as a visible minority. French is one of the top three languages spoken at home other than English in the neighbourhoods of Casa Loma, University and the Annex.

The City of Toronto is one of the 26 French Language Services (FLS) designated areas in Ontario. Six identified providers under the French Language Services Act (FLSA) are located in MWT; Centre for Addiction and Mental Health, Hospital for Sick Kids, Sinai Health System, Women's College Hospital, University Health Network and Toronto Region-Home and Community Care.

Centre Francophone du Grand Toronto (CFGT), a designated service provider under FLSA, has been a long-standing partner in MWT, historically offering services through the SPIN (Solo Physicians in Need) Community Health Centre (CHC) program and actively participating at the HealthLink and Mid-West sub-region tables since 2013.

CFGT is leading a critical initiative to redesign system navigation and care coordination for Francophones across the GTA-based Ontario Health Teams, under the auspices of the Working Group on System Navigation and Care Coordination for Francophones. The MWT-OHT has committed to being one of the first OHTs to partner with this Working Group in order to co-design and test this model of System Navigation and Care Coordination that would establish a proactive offer of French Language Services across our OHT. The initiative would seek to improve care and the overall health and wellbeing of Francophone patients and their families that are attributed to our Team. It will likely include, but not be limited to, awareness training on French Language Services (FLS) and Active offer of FLS to OHT partners, support for the MWT-OHT to meet French language requirements as needed and ensuring that health care models have streamlined pathways for Francophones.

This program is anticipated to be a long-term activity, which will be co-designed with French-speaking citizens and implemented over several years. That said, the MWT-OHT recognizes the near-term needs of this unique population, particularly as it relates to the challenges faced by the Francophone communities in accessing care and health information related to COVID-19 in French. Recognizing that increased

collaboration and cooperation are pivotal in addressing some of these gaps, CFGT is an engaged member of the MWT-OHT COVID-19 Second Wave and Flu Season Coordinated Response Working Group. We will continue to leverage the services offered by CFGT to ensure services for Francophones including newcomers in our region.

Further to the need for better coordinated COVID-19 supports, the MWT-OHT also acknowledges the anti-black racism that many in the Francophone community face in the health care system. And so, as we take proactive steps to addressing inequities in care and health outcomes, we will continue to engage our partners at Centre Francophone du Grand Toronto in ensuring multiple barriers to accessing equitable care are identified and addressed for the Francophone community.

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

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

Max word count: 500

Since inception, the partners of the Mid-West Toronto Ontario Health Team have seen the OHT as a unique opportunity to address gaps in care for structurally vulnerable populations in downtown Toronto. Our Year 1 priority populations reflect a focus on reimaging and co-designing care for these most vulnerable groups; recognizing that if you build a system for those facing the most barriers, that system will bring improvements and benefits for everyone else.

When COVID-19 hit the city earlier this year, its disproportionate impact on marginalized, racialized and Indigenous groups further underscored the disparities that existed pre-pandemic for these groups and the desperate need to acknowledge and address the inequities in health and health care that have long existed. This reality, coupled with the ongoing pain and outrage associated with anti-Black and anti-Indigenous racism in Canada, sparked by the recent events both locally and in the USA, emphasize the need to confront and address the structural racism that is embedded in our health care system.

Hence, within this context and history, we will identify actionable, sustainable, and measurable next steps towards improving the health status of Indigenous and racialized groups within the Mid-West Toronto region. These initiatives will build off the foundational work of Indigenous organizations, the former TCLHIN and Toronto

Public Health, whom together created A Reclamation of Well Being: Visioning a Thriving and Healthy Urban Indigenous Community, the first Indigenous Health Strategy for Toronto; and The Urban Indigenous Action Plan, a policy framework that was co-developed by the government of Ontario (Ontario), the Ontario Federation of Indigenous Friendship Centres (OFIFC), the Métis Nation of Ontario (MNO), and the Ontario Native Women's Association (ONWA). Also the work of Black communities, the Black Health Alliance, the Toronto Region Anti-Racism Steering Committee, and the GTA CHC Network's Anti-Black Racism Initiative, among others, all of which underscore the importance of this work being rooted in engagement with Black and Indigenous communities.

In Year 1, we see two key areas of opportunity:

1) Building off the work of the GTA CHC Network, we intend to support the implementation of the Anti-Black Racism Audit Tool across the OHT partnership, which seeks to identify gaps in culturally safe programming, availability of socio-demographic and race-based data, meaningful engagement with the Black community, and anti-racism policies and culture within organizations.[1]

2) Building off the recommendations of the Black Experiences in Health Care Symposium, the OHT will support socio-demographic and race-based data collection spanning across the continuum of care, not just in hospitals and Community Health Centres, to improve data quality, analysis, and the ethical and accountable utilization of the data to advance actions that will positively impact the lives and outcomes of Black communities accessing care. This data is essential to draw attention to differences in illnesses, access to services and health outcomes and will be a critical step in not only improving the health status of the Black community but of all communities marginalized by factors like race, language, sexual orientation or immigration status. [2]

3) Advancing recommendations to enhance and build culturally safe services for Indigenous Peoples and collaborate with Indigenous-led organizations in advancing actions and strategies that will address and support improving the social determinants of Indigenous health. [3]

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

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

Max word count: 500

Specific subpopulations within the Mid-West Toronto experience greater challenge with social distancing and other infection prevention and control practices. Though not exhaustive, this higher risk category includes those who interact with the shelter and drop-in system, those living in congregate settings and those with inconsistent access to reliable public health guidelines or resources.1 In alignment with the overarching goal of the MWT-OHT to remove barriers for the most vulnerable in our community, we will continue to advance response initiatives that coordinated care delivery and reduce the risk of infection for these communities as outlined below.

a. Shelter and Drop-In

Individuals experiencing homelessness are limited in their ability to follow physical distancing measures given the structure of shelters, drop-ins and encampments. The swift response by the Toronto Region Homeless Table and establishment of recovery sites helped to mitigate this otherwise unavoidable risk for homeless individuals under investigation for COVID-19. These sites provide clients with sufficient space for isolation, access to needed PPE, and community-focused care including peer support, harm reduction support and other health and social supports. This response table, largely consisting of MWT-OHT partners, plans to continue to operate recovery sites as needed for the duration of the pandemic.

b. Congregate Settings

Similar to the above population, those living in congregate care settings seldom have the opportunity or privilege of physical distancing. Recognizing that most of this population must remain in situ to receive optimal care, partners in the Mid-West have collaborated to ramp up Infection Prevention and Control (IPAC) in these settings through Resource Partnerships. This sustainable method of IPAC resource provision was established during the first wave of the pandemic in the LTC, Home and Community Care and MHA sectors amongst others. For example, the Toronto Region Mental Health Working Group Table (chaired by MWT partners, CAMH and LOFT) created an MHA Resource Partner list to pair all MHA community agencies in need of IPAC support with a resource partner. The MWT-OHT will work to support and grow these established resource partnerships in order to preserve the safety of any person living in a congregate setting.

c. Inconsistent Access to Resources

Mid-West Toronto OHT COVID-19 Wave 2/Flu Season Coordinated Response Working Group has been formed to develop a framework for a coordinated response to a COVID-19 Second Wave and concurrent Flu Season for the MWT-OHT. (See Appendix 5 and 6 for Working Group's Terms of Reference and Planning Framework, respectively). Central to this Working Group's mandate will be the delivery of cultural and language appropriate resources to structurally vulnerable subpopulations.

With three key pillars, the Working Group will focus on:

1. Developing and/or facilitating the distribution of simple, accessible health promotion materials with common messaging in multiple languages.
2. Develop a flu vaccination strategy that is embedded in the community.
3. Develop a centralized support program for small community agencies to support more consistent PPE access to settings with previously precarious supply chain and IPAC guidance that is appropriate to the care setting.

Two key takeaways from the first wave were the importance of flexibility as well as the reality that the pandemic affects certain populations disproportionately. As part of its mission, the W2F Working Group will work to find the gaps in community2 response to COVID-19 and to fill them quickly.

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

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

Max word count: 1000

"As a patient advisor to the MWT-OHT Executive Project Advisory Committee and the Wave 2/Flu Coordinated Plan Working group, I feel optimistic for three reasons: 1) I am brought along early enough in the work to influence our outcomes; 2) I see others with lived experience embedded in our peer support work, our committees and our service design and 3) we do not seem to being doing the same old. We are doing the complex work of developing new systems by starting at a grass roots level with people with lived experience and then consulting with expert care providers to bring ideas to reality."

Mike Creek, Patient Advisor

The MWT-OHT will build on the years of intentionally inclusive community engagement work by our partners to keep patients and local residents central in co-design, peer support work, evaluation, and governance. The MWT Partners recognize that in order to design a health care system that works for the most vulnerable, the most vulnerable voices must be at the table and adequately represented.

The developing MWT-OHT continues the commitment to ensuring that patients and caregivers have a voice at every step along the design and implementation of the OHT. Patients and caregivers are members at each level of planning, including the All Partner Table, the Executive Project Advisory Committee, and the various working groups.

The MWT-OHT and our partners recognize the value of the peer support worker in promoting the health of our population and specifically the more structurally vulnerable. We are

committed to building on this organizational competency, to create further workplace opportunities and to keep peer support workers central in co-design.

The UHN OpenLab team, which is leading our design efforts for those with substance use challenges, is philosophically aligned with the OHT in this regard as their Service Design methodology incorporates the voices of those with lived experience at every single decision point. Not only do they have a broad interview and engagement strategy, they also embed individuals with lived experience into the design team, helping with decisions like how interviews should be structured, which questions to ask our data specialists, and how to prototype care.

The MWT-OHT created a Patient and Community Engagement Strategy which considers how and when individuals will be engaged, along with how they will be compensated for their participation in this work. (Please see Appendix 7 for the Patient and Community Engagement Strategy). The MWT-OHT has therefore created a community pool of funds specifically to support the patient and community engagement and co-design process, along with other vital planning expenses. This centrally administered, transparent system of financial accountability to receive, disburse and manage resources for the collaborative is a unique feature of our OHT.

As we work to address inequities in care and health outcomes, we will work with individuals who represent the rich diversity of the population we serve to ensure that we are providing culturally safe care that is accessible to all. We will build on initiatives such as the Neighbourhood Care Teams by The Neighbourhood Group, Parkdale Queen West CHC, West NH and others. The Kensington NCT and Roncesvalles NCT have had significant involvement by non-English-speaking immigrant seniors in TCHC housing in the co-design of the NCT as well as providing forums for ongoing input about the NCT work. Understanding and removing the barriers to participation typically encountered by vulnerable populations will be an ongoing process for our Team. This process will be iterative and flexible in order to respond to patient-reported outcome measure data and feedback.

5.0. Implementation Planning

5.1. What is your implementation plan?

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

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

Max word count: 1000
See attached table.

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

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

Max word count: 1000
Inter-OHT Coordination

Recognizing that our attributed population does not exclusively access services from providers within our OHT, the MWT-OHT acknowledges that there is a significant need for information-sharing and coordinated planning across OHTs, especially with those who share our borders. A coordinated forum for local OHTs would enable best practice sharing, joint planning where appropriate, and the efficient scaling of services across the region where appropriate. Though proactive coordination with neighbouring OHTs is already underway, a formal, centrally coordinated Toronto OHT Forum would be beneficial.

Semi-Annual Data Refresh
A semi-annual refresh on the MWT patient attribution data sets will allow us to track the development and growth of our OHT and will be critical to our timely understanding of our population. The updated data will also help to inform where future partnerships as well as cross-collaboration with adjacent OHTs should be explored.

OHT Governance Support
As the MWT-OHT embarks on conversations related to governance, accountability and Collaborative Decision-Making Agreements, the Team would benefit from support and guidance related to successful Board-to-Board dialogue. This will be helpful as we strengthen our foundational trust, and progress toward joint financial and clinical accountability at maturity.

Digital Health Strategy Supports
Our digital health strategy would benefit from:
• A refresh of the digital playbook, highlighting where local OHT priorities can align with provincial priorities in Years 1 and 2.
• A regional or provincial Digital Health Community of Practice that would enable sharing of lessons learned, best practices, and other resources to support OHTs in building capacity for virtual care.

• Clarity around the roles and responsibilities within Ontario Health would facilitate a better understanding of how to utilize the various supports (i.e. OTN, OntarioMD, eHealth Ontario, and Regional Digital Leads) to build our virtual care capacity.

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

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

Max word count: 1000

Long-Term Care COVID-19 Commission:
Current provincial activities targeting the improvement of Long-Term Care will be key enablers for our OHT. The recently released MOH Staffing Advisory Committee and Long-Term Care COVID-19 Commission, to be completed by April 2021, will hopefully result in much-needed improvements to LTC homes' ability to prevent, isolate and contain the spread of COVID-19 and other infectious diseases. Recommendations from the report may lead to new opportunities to develop new models and partnerships in caring for our Frail Seniors, ultimately keeping people healthy at home in LTC.

Home and Community Care Legislation:
The forthcoming Home and Community Care legislative, regulatory and policy changes will allow OHTs to more readily redesign care. With the ability of the OHT (or other Health Service Provider that is part of the developing OHT) to deliver home care, we remove the added challenge of obtaining community designation, which will be a key enabler in coordinating care. Having this active service delivery function within an OHT will allow for improved integration and collaborative decision-making around a key service, paving the way for further evolution of the OHT.

However, we do notice that there is no mention of the homeless population in the legislation and hope that this is appropriately addressed in the regulations and policies that stem from the legislation.

Need for better integration of policies addressing health and social needs:
Our population has experienced the stark inequities that the pandemic has laid bare for structurally vulnerable people. There is overwhelming evidence indicating that the social determinants of health are key in maintaining health and well-being, yet the various ministries (Health, Housing, Community and Social Services) have legislation that can be conflicting for someone with challenges accessing housing, health care, and/or financial support. Integrating social and health needs by developing a liaison function among these ministries would help to enhance our work with this population.

Supporting non-Healthcare-funded services:
The vulnerable people our OHT intends to support often seek care from non-healthcare-funded services providers (i.e. CSS/Drop-ins). The pandemic has highlighted stark differences between healthcare and social sector-funded

organizations. For example, while healthcare-funded drop-in centres had adequate access to personal protective equipment and expertise as well as information and communication related to IPAC, this was not the case for social sector-funded organizations. As a result, only 9 of 52 drop-ins were able to remain open, resulting in a significant gap in services for our priority populations. Standardizing resources and information regardless of funding source will be a key enabler to improving the health of our population.

Standardized/Funded Approach to Physician Compensation for Participation in OHT Planning:
Another key barrier is the lack of consistent, standard policy addressing compensation of physicians – specifically Fee-For-Service primary care physicians - for their participation in the planning and implementation of the OHT. Significant engagement with primary care is critical to the success of OHT, and without a consistent and funded approach across OHTs we run the risk of losing the interest and engagement of our primary care providers. Furthermore, in an urban environment like Toronto, with its complex referral patterns, we need physician engagement to ensure a deep understanding of the primary care models and any downstream impacts of shared clinical accountability across the OHT as we approach maturity.

5.1 Implementation Plan

Population/workstream	3 months	6 months	12 months
Year 1 Priority Population: Homeless & Underhoused	Resource assigned to this work. Planning for co-design started. Engagement of peer support workers.	System is co-designed; peer support workers trained in the three areas: primary care attachment, case management attachment and MHSU support attachment	
Year 1 Priority Population: Frail Seniors	LTC: 1-2 webinars and 2 inservices (LTC+) completed with specific partner LTC homes. LTC homes supported through wave 2 outbreaks by HRPs. Calls increased by 10% at 3 months.	LTC: LTC+ calls increased from baseline by 20%, 2-3 webinars and in-service education. Engagement of additional homes.	LTC: Ongoing HRP-LTC partnership established and implemented. LTC+ calls increased by 30% from baseline - 2 further webinars/inservices completed. Scaling and expansion of program and related measurement.
	CSS: PSW training designed: 1) virtual care technology support and 2) activation under direction.	HCC/CSS: Training initiated for PSWs in virtual care support. Understanding implications of new HCC regulations and considering directions for our OHT.	HCC/CSS: PSW training reviewed; plans developed for deployment with partners (e.g. OT,PT, primary care).
	Primary Care: Process established to connect virtually to support homebound seniors.	Primary care: 10-20 practices have used this virtual service.	Primary Care: 20-40 practices have used this virtual service.
Year 1 Priority Population: Mental Health & Substance Use	Final 3 Months of Openlab Design Project #1 (DP#1). Service Blueprint received in December.	Service Blueprint presented to Partners and proposed intervention rolled out. Baseline survey completed. Connect via SCOPE Hub to engage community practices.	Continued rollout of service blueprint.
Key Workstream: Digital Health Program Development	Digital Health working group re-engaged.	OHT's Digital Health Program created and governance established. Monitor organic adoption of digital tools.	Digital initiatives prioritized in alignment with MWT OHT priorities.
Key Workstream: Expansion and scaling of SCOPE (Seamless Care Optimizing Patient Experience) and SPiN (Solo Practitioners in Need)	SCOPE: Range of community supports expanded to the current 170 SCOPE physicians, e.g. support for fragile seniors, ongoing pandemic support, support for people with substance use challenges.	SCOPE: 30 physicians added (assuming support for augmented staffing)	SCOPE: 50 physicians added (assuming support for augmented staffing)

Population/workstream	3 months	6 months	12 months
	SPiN: increase number of agencies offering services through SPiN to non-CHC community based agencies; test SPiN referral portal	SPiN: promote and release SPiN referral portal	SPiN: increase number of solo MDs participating in SPiN by 20%
Key Workstream: COVID-19 Second Wave/Flu Season Coordinated Response	Flu vaccination strategy is intiated. Centralized support program is available to small community agencies for PPE access/IPAC support. Health promotion materials are developed. Coordinate support/information for Primary Care offices and community agencies.	Program is monitored and adjusted as necessary.	Next flu season plan is completed.
Key Workstream: Anti-Black Racism	Establish a Health Equity working group for the OHT. Anti-Black Racism Audit Tool implemention plan is developed.	Anti-Black Racism Audit Tool implemented across OHT partners. Audit race-based data collection across partners organizations.	Anti-Black Racism Audit Tool implemented continued across OHT partners.
Key Workstream: System Navigation and Care Coordination for Francophones	Health Equity working group established for the OHT. MWT-OHT representation on the Francophone-led Working Group on System Navigation and Care Coordination for Francophones.	Direction taken from Centre Francophone working group re: toolkits/materials/ training to disseminate in our region.	Direction taken from Centre Francophone working group re: toolkits/materials/ training to disseminate in our region.
Key Workstream: Indigenous Health & Allyship	Defer to Anishnawbe Health and its Indigenous OHT in development for guidance on next steps and timelines for our collective and mutually respectful work in building a health care system that fosters dignity, peace and prosperity for Indigenous People.		
Key Workstream: MWT-OHT Governance	CDMA completed. Governance structure drafted with endorsed partners	Governance structure approved and implemented.	

Appendix 1 – References

Section 1.1

[1]Public Health Agency of Canada. "Population Health Approach" Ottawa: 2013.
[2]Orkin AM AFM 2017:405-409.

Section 1.2

[1] Note: There is large variety in the capacity, attendance and days open at each drop-in location in the Mid-West Toronto. This number is meant to provide a daily average of the number of drop-in visits across the MWT accounting for available data on location capacities and # of days open/week. This as an area for data refining and validation in service planning.
[2] Toronto Central LHIN Hospital (FY 2017/18) and Home & Community Care Utilization (FY 2017/18 & 2018/19) by Those Experiencing Homelessness (December 2019)

Section 1.3

[1] LHIN Sub-Region Data August 2019
[2] Q4 2019/2020 Health Equity Data collected by UHN, WCH, SHS, CAMH, AA, PQWCHC, DPCHC, CFDT
[3] Toronto Pubic Health COVID-19 Neighbourhood Characteristics Dashboard (2016 Census Data)
[4] Streets Need Assessment 2018 – Results Report. City of Toronto
[5] LHIN subregion data 2019 – 2016 Census
[6] Retrieved from: http://longtermcareinquiry.ca/wp-content/uploads/Exhibit-169-Long-Term-Care-in-Ontario-Sector-overview.pdf
[7] CAMH Data Request: Demographics- Substance Use Patients, FY 2019-2020, Retrieved Aug 31, 2020
[8] CAMH Interpretation Services Data 2019-2020.
[9] Drug and Addictions Treatment Information System (DATIS) custom data request
Time period: September 1, 2019 to August 31, 2020

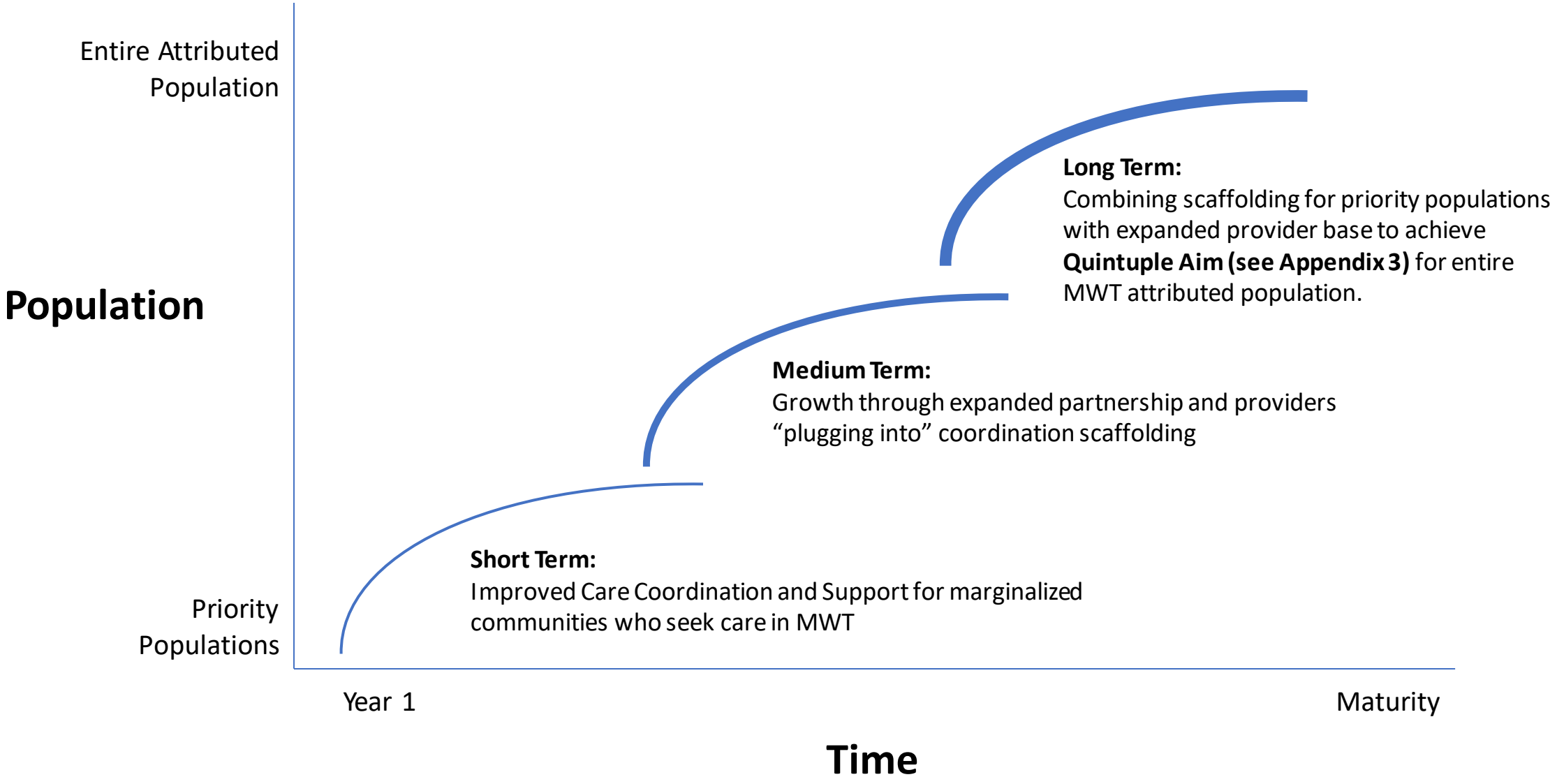
Section 4.3.2

[1] Office of the French Language Services Commissioner of Ontario, 2017-2018

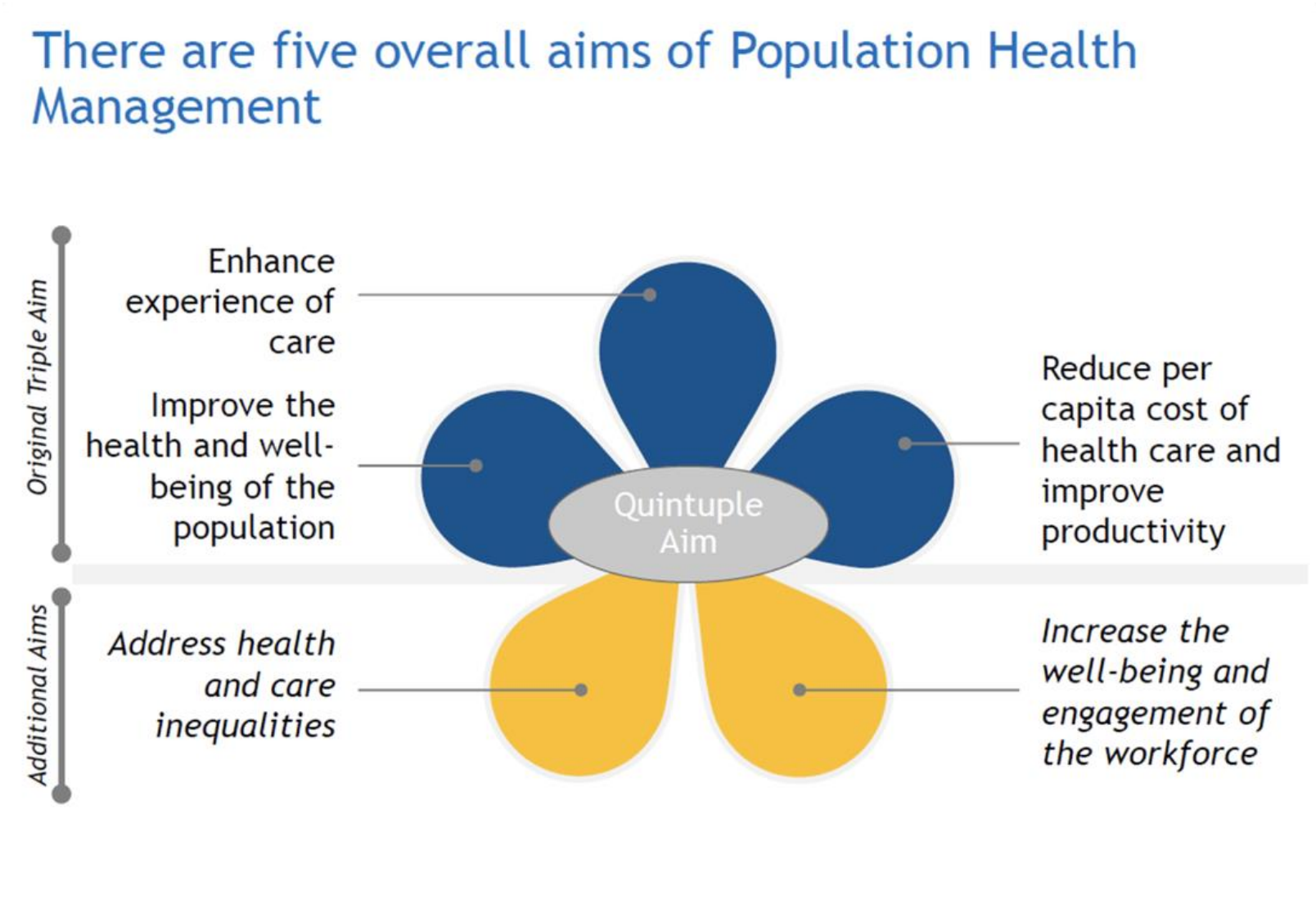
Section 4.3.3

[1] GTA CHC Network Anti Black Racism Organizational Survey - July 2020
[2] BLACK EXPERIENCES IN HEALTH CARE SYMPOSIUM: Bringing together community and health systems for improved health outcomes – April 2020
[3] A RECLAMATION OF WELL BEING: Visioning a Thriving and Healthy Urban Indigenous Community Toronto's first Indigenous Health Strategy 2016-2021

Appendix 2 – MWT-OHT Population Planning Horizons



Appendix 3 – Quintuple Aim



Retrieved from: http://twoharbourshealthcare.co.uk/population-health-management/

Appendix 4 - List of Existing MWT Collaboration Initiatives

This list represents a collection of collaboration initiatives among the partners in the Mid-West Toronto OHT. It is broad list of initiatives that represents many sectors and patient populations, however it not exhaustive.

1) **SCOPE Seamless Care Optimizing the Patient Experience:** SCOPE acts as a virtual interprofessional team to solo practicing family physicians serviced by UHN hospitals. Through a single point of access, registered SCOPE physician users can speak with an Internist-on-Call, dedicated CCAC Care Coordinator, Nurse Navigator, and a Radiologist on-Call. For more information, visit www.scopehub.ca. 126 community physicians registered and 100% are using the service. Over 5000 calls since 2012 with 64% of calls deemed to have avoided an ED visit.

   As a part of SCOPE, there are also the following programs (ii-iv):

   i. **Medical Imaging Call Centre-** The call centre is for primary care providers designed to improve integration with medical imaging. This provides a central point for imaging inquiries, coordination of call by a clerical staff and real-time consultation with a radiologist.
   ii. **Same day imaging –** Provides the opportunity for patients from Toronto Western and Women's College to walk in with completed requisitions and receive imaging without an appointment for Nuclear Medicine, Ultrasound and X-ray.
   iii. **MRI standby list –** Provides patients who more urgently require an MRI the next available slot
   iv. **Cancer-** Support primary care physicians to improve integration for cancer patients with physician advisory group

2) **SPiN:** A connecting and placement service coordinated by Access Alliance that acts as a Central Point of Access connecting primary care patients to the community resources they need on behalf of their most vulnerable patients.
3) **Enhanced Home at Last (EHAL):** A pilot project led by West Neighbourhood House involving eight community support agencies providing transportation and escort services for patients at highest risk for readmission (e.g. patients with CHF, COPD, CAP and GI) on the day of their transition from hospital and additional PSW services to support these patients in the community for up to a maximum of 12 weeks.
4) **OnBoard:** A program run by Access Alliance that provides better access to services, linkages and pathways for residents of Ontario with irregular status (non-insured or under-insured) that face barriers to accessing healthcare.
5) **Neighbourhood Care Teams (NCTs):** West Neighbourhood House and The Neighbourhood Group have both led the development of Neighbourhood Care Teams in the Niagara and Kensington-Chinatown neighbourhoods respectively. NCTs are integrated models of care that are accountable to meeting the needs of people living within a high-density urban neighbourhood. People will experience one system that provides simple access to service,

navigation / coordination if unable to self-navigate, and streamlined communication of health care providers.

6) **Urban Health Network:** a single point of accountability to ensure collaboration between Community Support Sector Providers (CSS), Home and Community Care (HCC), hospitals and primary care.
7) **Short-term Transitional (STTCM) Care Model:** A regional system of care across Toronto Central LHIN involving 16 community health service provider partners including many providers in the mid-west such as LOFT, UHN, WNH, WTSS, Bellwoods, Toronto Central LHIN and Reconnect, all working towards reduction in ALC days through provision of over 200 Reintegration Care Units (RCUs) (bedded spaces) across 12 locations in Toronto as well as Caregiver Relief Services (CRS) to support caregivers consider returning home in Toronto to continue care of their loved ones in community. The providers work collaboratively to collate/create and execute recommendations for standardization in policy and practice, using data, staff and client surveys. This has resulted in the evidence-based evolution of the program and solidified the quality of the care, focused on the client and caregivers needs.
8) **Centralized Referral Management Team:** Created at Bellwoods in collaboration with the STTCM partners to be the central point of referral, screening, education, navigation and resources. Since its launch in March 2018, which included creation of a standardized referral form for all the programs, central intake fax system and single point of contact by phone, the CRM Team have worked on >1800 referrals and managed daily consult calls from 21 different hospitals and some community partners. Each referral is vetted by a staff and either matched to one of the 16 providers, waitlisted or a request for further information is made within 1-3 hours. The CRM Team evolved to also offer waitlist management services for the system and individual providers. The CRM Team are working on adding other non-STTCM partners and are in the final stages of creating an electronic referral portal with their IT partner, Caredove.
9) **Edgewest Clinic:** has been a successful collaboration between Davenport Perth CHC, Planned Parenthood, LOFT Community Services, The Neighbourhood Group and youth at risk to develop and sustain a primary care and mental health/substance use treatment clinic for youth
10) **Integrated Community Health Primary Care:** The five (5) CHCs that have been active in the mid-west region (and HealthLink) act as an Integrated Primary Health Care Network in many ways. We serve most vulnerable and marginalized in the sub-region and have the capacity to amplify how we provide access to interdisciplinary teams, partner with other PC models and broadly address SDOH. We can strengthen partnerships and pathways that will support full integration at OHT maturation.
11) **TC LHIN Home and Community Care:** 24-hour access to telephone or digital support connecting patient and/or provider to the right health care service in the right order at the right time and in the right setting
12) **Inner City Health Associates (ICHA):** A group of 100 physicians including, primary care, psychiatry, and internal medicine, providing transitional primary, psychiatric care and outreach based palliative care to people facing homelessness across 52 shelters, dropins and respite sites across the City of Toronto, including 12 different sites in the Mid-West region with plans to serve an additional 15 sites.

13) **Health Action Theatre Program:** an interactive health literacy program that allows elderly seniors whose first language is other than English to learn about navigating the health care system and self-managing their own care through interact community theatre program led by West Neighbourhood House.
14) **The Rescue Network:** A project co-designed with street-involved opiate users, and Naturally Occurring Retirement Communities (NORCS) – An innovative project being co-designed with older adults who wish to age in place.
15) **The RED Project** (Referrals from the Emergency Dept): Patients presenting to UHN ED with 4+ ED visits in the past 6 months and are not attached to primary care are flagged. The patient is connected to a CHC/FHT for primary care attachment via the ED Social Workers. Average of 6 patients per month leave the ED with their first primary care appointment scheduled.
16) **Toronto Community Addiction Team (TCAT)** ED Integration: Patients who suffer from severe substance use issues that present at UHN ED are flagged to the ED Social Worker and appropriate community case manager to connect and coordinate care in response to patient's visit and transition back to community. ED visits for TCAT clients were reduced by 45% over first year of this program.
17) **Hospital Frequent Visitor Algorithm:** A quarterly lists of patients with 4+ ED visits or 2+ unplanned admissions in the past 6 months are provided to primary care providers who have requested this information. Patients are triaged by primary care for a coordinated care plan or TIP clinic for medical consultation to initiate the coordinated care planning process with the goal of reducing future avoidable visits to hospital. 132 patients were flagged across 9 primary care organizations in the last quarter.
18) **CHOPPP (community and hospital pharmacist partnership for patients; now called PROMPT)**: UHN pharmacists collaborated to design a procedure for improving communication about medication needs at discharge for complex patients. Hospital pharmacists fax prescription to the community pharmacist and then follow-up by phone to confirm receipt and answer questions. Contact information is also provided so hospital pharmacists can be reached directly for follow-up if needed. 95% of community pharmacists who received a phone call in year in first 6 months of program believe communication enabled potential problems to be prevented. 100% would like to see this communication continue.
19) **Nursing Led Outreach Team (NLOT):** The Nursing Led Outreach Team is comprised of a team of acute care nurses who provide direct care to patients and education to their peers working in Long-term Care Homes. The NLOT was designed to build nursing skills within LTCH and to provide some acute care. This team has improved the depth of care in LTCHs by enabling early intervention, palliative care and emergency department avoidance so residents can remain in their homes as opposed to coming to the emergency department for treatment.
20) **Toronto Community Housing Corporation (TCHC)**: TCHC buildings with a high number of EMS calls were targeted for this initiative to better-integrate providers in order to champion cross-agency collaboration, improve efficiency and better serve clients. All providers serving a building were assembled to establish coordination of care for residents with complex needs being served by multiple agencies.

21) **Coordinated Care Plan (CCP) at Discharge:** A patient-oriented discharge summary is provided to patients. This has been co-developed with patients using symbols and language that resonates with patients and answers to questions that help patients in hospital (e.g.., when to call, expectation of time for appointment etc.). This is currently under trial in 13 hospitals and so far, has found a reduction in people returning to hospital.
22) **Telemedicine IMPACT Plus (TIP)**: A clinical program offering one-time interprofessional team-based consultations to complex patients and their family physicians to derive new solutions for addressing the patients' chronic conditions. Physicians, patients, and their caregivers also benefit from the support of a dedicated nurse who enables the coordinated care planning process within the patient's circle of care. 46.2% fewer patients returned to UHN ED or inpatient in the 6 months post-TIP
23) **Independence at Home (IAH)**: A partnership program with CCAC, MSH and UHN, funded by Access and Restore Initiative provide a specialized Geriatric Outreach service providing Comprehensive Geriatric Assessment and Navigation for community based medically complex seniors with rehabilitative/ restorative potential to help them maintain their independence. Team members may include RN, OT, PT, Pharmacy, SW, MD based on patient's needs.
24) **Home-Based Primary Care:** Comprehensive primary care for older adults with complex chronic disease and social care issues at the home.
25) **Remote Patient Monitoring for Cardiac Patients:** To prevent patients from requiring re-hospitalization, UHN researchers have developed real-time remote patient monitoring technologies that report a patient's health at home. This keeps their health team informed and enables steps to be taken before the patient reaches critical condition. "Remote patient monitoring is designed to encourage patient self-care and caregiver empowerment, lessening the dependence on traditional care providers. This has shown to improve health outcomes while ensuring the financial sustainability of the program," says Dr. Heather Ross
26) **Mid-West Toronto Sub-region:** UHN is a Hospital Resource Partner for this sub-LHIN region, and provides in-kind support to the Mid-West Team, acts as a collaborative partner within the Tri-hospital collective, and helps support centralized intake to specific sub-specialties. UHN Digital is contracted to inform the Specialist Directory, e-referral and Secure Communications Bundle for the TCLHIN.
27) **Hospital-at-Home (H@H) and similar partial substitution acute care models:** This program is an integrated funding model project supported by the TC LHIN and developed in partnership with University Health Network, Sinai Health System, Women's College Hospital and the Mid-West Toronto Health Link. The H@H program is a partial substitution acute care model. Inpatients are assessed in the H@H program and inpatient level care is delivered in the patient's home, by a community partner organization (St. Elizabeth). The H@H team along with health disciplines provides regular scheduled visits in the home until the patient is transitioned to the community. Patient populations include COPD, CHF, LVAD, urology and dialysis.
28) **A-Fib Innovation:** A-fib innovation is directed at redesigning the system and process of care for atrial fibrillation (AFIB) to improve patients' quality of life and to improve the sustainability of the healthcare system from the Emergency room to the Family Doctor's office. It is run by collaborative team of Heart Rhythm Specialists, Neurologists, Internists, Family Doctors, Nurse

Practitioners, Pharmacists, Researchers, Designers and Engineers that span across multiple healthcare organizations including the Centre for Innovation in Complex Care at University Health Network, St. Michael's Hospital and the Taddle Creek Family Health Team.

29) Health Equity: UHN is collecting patient demographic information to ensure that every patient has access to the highest quality of health care that we can provide. By asking these questions we will get to know our patients and become better at providing care and services. Evidence shows that factors such as gender, race, sexual orientation, immigration status, and income can influence a person's access to timely, appropriate and high-quality care. Health equity is concerned with creating equal opportunities for good health for all and reducing avoidable and unjust differences in health among population groups.

30) **Discharge Summary Quality Improvement Program:** Focused on improving the quality, completion, and delivery of the ~35,000 discharge summaries at UHN to primary care. Tools and education have been approved by the Royal College, peer-to-peer and hospital to primary care groups. Education programs are currently being delivered to learners through UofT and the Wightman-Berris Academy on creating a quality Discharge Summary for Primary Care. To ensure sustainability, primary care membership has been included in the UHN Health Records Committee for ongoing feedback and communications - a first of its kind in Ontario. The project has improved performance from 50% to over 80% completion and 40% to 80% delivery.

31) **Inter-professional Spine Assessment and Education Clinics (ISAEC):** UHN has designed and implemented an inter-professional model of care for the province (Toronto, Hamilton and Thunder Bay) aimed at improving the quality and efficiency of Lower Back Pain (LBP) assessment and management in the community. ISAEC launched in November 2012 with three overarching objectives: 1) Decrease ordering of lumbar spine MRIs by PCPs (reduced by 27%) 2) Reduce unnecessary referrals to LBP-related specialists by PCPs (~90% reduction in inappropriate referrals to specialists) 3) Improve health outcomes and satisfaction with healthcare delivery for patients with persistent or recurrent LBP (98% provider and 94% patient satisfaction and 10 point improvement in their Oswestry Disability Index. In addition, the ISAEC program has introduced standardized patient flow and training for Primary Care and community based Advanced Practice Clinicians - enrolling over 450 Primary Care Providers with over 80% utilization rate treating over 6,300 patients.

32) **Extensions of Community Healthcare Outcomes (ECHO)**: ECHO empowers primary care providers in remote communities to treat complex chronic pain conditions of individuals across Ontario utilizing a specialist level of expertise. Expert specialist teams at an academic hub are linked with primary care clinicians in local communities. Primary care clinicians receive mentoring and feedback from specialists. Together, they manage patient cases so that patients get the care they need

33) **Medly**: Medly empowers patients by providing access to their personalized health information and encourages healthy behaviour by promoting patient self-management and self-monitoring. Patients can record blood pressure and weight every day at home, helping them and their clinicians to ensure that they are on-track. Through Medly, patients can also send and receive information about medications, lab results, and educational information directly on their

smartphones. Clinicians can remotely monitor a patient's health status on a computer and be notified through automated email alerts when their patients experience abnormal symptoms.

34) **LIFEspan Program:** The LIFEspan Service (Living Independently Fully Engaged) provides youth and young adults who have cerebral palsy or acquired brain injury (ABI) with a "bridge" between pediatric and adult rehabilitation services. The adult LIFEspan service at Toronto Rehab gives patients a single point of access for specialized rehabilitation with an emphasis on helping these young adults develop skills to manage their own care and navigate the adult system.
35) **Together in Movement and Exercise (TIME™):** is a community-based program focusing on people with balance and mobility challenges. The group exercise program is designed by physiotherapists at Toronto Rehab, and led by fitness instructors in community centers such as Waterfront NC. The program provides opportunity for participants to exercise in their neighbourhood.
36) **PM Integrated Cancer Journey:** Patient-designed, patient-facing 'My Cancer Journey' toolkit for navigating the health care system as a cancer patient and partner in care. This toolkit enables peer support amongst patients, access to hospital and community services, and resources for areas affecting everyday life for cancer survivors.
37) **PM Education and Outreach:** With the UHN Primary Care Lead, Pauline Pariser, we have hosted CME Accredited continuing education sessions with community physicians on various oncology topics. Sessions include lectures, discussions, questions, and networking. These events are an opportunity for Princess Margaret to educate primary care providers on current oncology trends for diagnosis, treatment, and symptom management support. We also showcase UHN and specialized Princess Margaret services and programs. These events also develop and strengthen relationships with community practitioners. We also seek direct feedback from the participants on areas for improvement in patient care delivery and communication. PM has have committed to hosting education events twice a year and to date we have hosted 6 engagement events (totaling 200 participants).
38) **ELLICSR:** Is a health, wellness and survivorship centre for cancer survivors (defined to be anyone who is touched by cancer, including patients, families, friends, and caregivers). ELLICSR offers information on health and wellness, opportunities to share and hear from other survivors, participate in classes or programs.
39) **Toronto Urban Health Alliance (TUHA**): A partnership that includes 6 community health centres and UHN, TUHA enables and improves access to psychiatrists and mental health services through a shared care model. This program strengthens the Health Centre's capacity to meet the mental health needs of the clients through direct service and clinical consultation.
40) **Gerstein Centre Harm Reduction Partnership with Ossington Men's Detox:** The Ossington Men's Detox has partnered with the Gerstein Centre Harm Reduction Service to offer men a safe and supportive living arrangement for up to 30 days. These men, while still using substances, do have a safe place to live and access to 24/7 supportive counselling should then need it. The service is staffed by both UHN and Gerstein staff who wrap support around the men as they attempt to gain control of their substance use.
41) **Shared care with Jean Tweed Centre for Women:** UHN Addiction Specialist provides addiction consultations at the Jean Tweed Centre for Woman bi-weekly. JTC is an addiction treatment

service for women. This partnership allows for patient-centred access to psychiatric services and enables the patients to transition to outpatient services at UHN in a more integrated way.

42) **Integrated Behavioural Group Therapy Service (IBGT):** The IBGT partnership is a three-partner treatment and capacity building initiative that is now about 3 years old. The partnership is designed to build capacity with a strong educational component. Initially staffs from each of the partners were provided with didactic education and clinical supervision in this model of therapy. Groups were launched at TWH and co-lead by staff from the partner organizations (Obrigo and Hong Fook), until each organization felt they could launch groups within their own setting. The model is now offered independently at all three organizations offering patients from three different language groups – those that speak Portuguese, Mandarin and Cantonese an opportunity to address their mental health issues in a group setting. Patient satisfaction is highly rated as are patient outcomes.
43) **Partnership with Savard House and IMPACT**: The TWH Assertive Community Treatment Team or IMPACT has developed a partnership with a homeless shelter, Savard House to provide support to long term residents of the shelter. These residents have been homeless for many years and suffer from chronic and often untreated mental health and physical illnesses. The goal of the partnership is to help the women transition to supportive housing, to improve their mental health care and to begin to address their physical health care needs. These are patients that are highly vulnerable and for whom the health care system has often not met their needs. To date 3 of the women have been permanently housed. Additionally, the staff at Savard House, who have not had mental health training are now receiving coaching and guidance for the IMPACT staff about how to support the women who come to the shelter.
44) Parkdale Houses Initiative: UHN owns several homes near the Bickle Centre, two of which are currently vacant. Work is underway to determine how we can provide transitional or community-based care in this setting to address gaps in service and to improve the continuum of care.
45) **Hillcrest Reactivation Centre:** UHN's Hillcrest Reactivation Centre opened in November 2017. This 75-bed centre offers re-activation services for patients who no longer require acute care from the TCLHIN hospitals. UHN partners with a community service provider, St. Elizabeth, to deliver care in this community setting.
46) **Long Term Care Expansion:** UHN has submitted a proposal to the Ministry to open a new LTC home beside the Bickle Centre and Lakeside LTC, on existing UHN property. The TCLHIN is facing a significant reduction in LTC beds in the coming years and requested such proposals across the city.
47) **COVID-Screening for Residential Care:** St. Michael's Homes' Residential Addiction Treatment Program, Renascent and Women's College Hospital have partnered to streamline COVID-19 testing for clients prior to admission to Residential Treatment. Testing appointments and results are a shared process to ensure clear and timely access to tests and results as part of the process of admission to St. Michael's Homes.
48) **Addiction Medicine in Residential Treatment**: True North Medical Centre provides weekly on-site Addiction Medicine physicians at St. Michael's Homes' Residential Treatment Program, ensuring a shared care model for access to OAT and other medical treatments for substance use challenges.

49) **The Mentoring, Education and Clinical-Tools for Addiction (META:PHI)**: Primary Care – Hospital Integration Project program led by Dr. Meldon Kahan at CAMH. This section should highlight Women's College Hospital META:PHI work that is a model centred on primary care integration and Rapid Access Addiction Medicine sites within the Mid-West. The META:PHI care pathway is a fully integrated system in which patients receive evidence-based care at every step. Discussed at numerous OHT meetings. See model here: https://www.metaphi.ca/the-model.html

Appendix 5

Mid-West Toronto OHT
COVID-19 Wave 2/Flu Season Coordinated Response
Working Group (W2F Working Group)
Terms of Reference

1. Composition/Membership

The W2F Working Group shall be composed of:

(a) Partner(s) of the Mid-West Toronto OHT table who will be Co-Chairs;
(b) Patient advisor(s)
(c) Family/Caregiver Representative(s)
(d) Partners of the Mid-West Toronto OHT Table,
At least one representative from:

- Hospital
- CHC
- Primary Care
- CSS
- MHSA
- LTC
- TPH
- FLS

Currently:

- Cliff Ledwos, Co-Chair (Access Alliance)
- Justine Humphries, Co-Chair (OHT Secretariat)
- Mike Creek, Patient Partner
- Dr. Camille Lemieux/Dr. Noah Crampton (TWH-FHT)
- Tammy Decarie (DPCHC)
- Lidia Monaco (The Neighbourhood Group)
- Jill Shakespeare (CAMH)
- Stanislas Mian Etiegne (Centre Francophone)
- Sagal Ali (Kensington Health)
- June Zhang (Yonge Street Mission)
- Eric Thomson (Toronto Public Health)
- Dr. Sarah Doyle (Primary Care)
- Jane Williams (UHN Connected Care)
- Edward Aust (OHT Secretariat)
- TBC, Community Pharmacy

2. Chairs

The Co-Chairs of the W2F Working Group will be Justine Humphries and Cliff Ledwos.

The Co-Chairs will be responsible for: agenda development and circulation, meeting management, circulating time and location of meetings, and reporting back to EPAC.

3. Scope/Purpose

The W2F Working Group has been formed to develop a framework for a coordinated response to a COVID-19 Second Wave and concurrent Flu Season for the Mid-West Toronto OHT (MWT-OHT). The W2F will be responsible for ensuring that the various pillars within the framework are being implemented and executed in a coordinated manner and in alignment with the MWT-OHT Guiding Principles. Act as a central control table that monitors performance of the coordinated response, particularly as it relates to our priority populations, addresses gaps in the response, and helps coordinate solutions.

4. Delegation of Authority

The MWT-OHT Executive Project Advisory Committee delegate authority herein described to the W2F Working Group, on the terms outlined below.

5. Responsibilities of the W2F Working Group

The W2F Working Group shall:

- Develop a framework for a coordinated response to a COVID-19 Second Wave and concurrent Flu Season for the Mid-West Toronto OHT (MWT-OHT) which considers at least the following pillars:
    a) Health Promotion. Special Considerations include:
        a. Individual safety practices: Handwashing, Masks, physical distancing
        b. Tackling Misinformation about vaccines
        c. Determining Key messages and how to get the right information to the community and community agencies?
        d. Language Services
    b) A Centralized Respiratory Assessment Centre and Network of COVID Testing and Flu Vaccination Sites. Special considerations include:
        a. Multiple access points
        b. Needs of agencies
        c. Needs of solo practitioners
        d. Mobile service
        e. The role of Pharmacies
    c) IPAC. Special Considerations include:
        a. Universal precautions and standard precautions
        b. PPE Sources
    d) The role of digital.
- Oversee the implementation of the framework and ensure it maintains central coordination.
- Monitor performance of the various response initiatives, particularly as they relate to our priority populations.

6. Accountability

The W2F Working Group is accountable to the EPAC and the patients and families attributed to the Mid-West Toronto region.

7. Length of Commitment

Length of Commitment: 1 year starting August 2020, to be reviewed after 1 year.

8. Meeting Frequency and Location

The W2F shall meet at the call of the Chair(s). Meeting frequency will be determined based on tasks and timelines. There will be approximately one meeting every two weeks during the planning phase. Meeting frequency will be reviewed for implementation and monitoring phases. Meetings will be held virtually. In person meetings will be used as appropriate.

9. Secretariat

The Secretariat will be responsible for meeting organization as well as minute taking. Action minutes will be distributed by email.

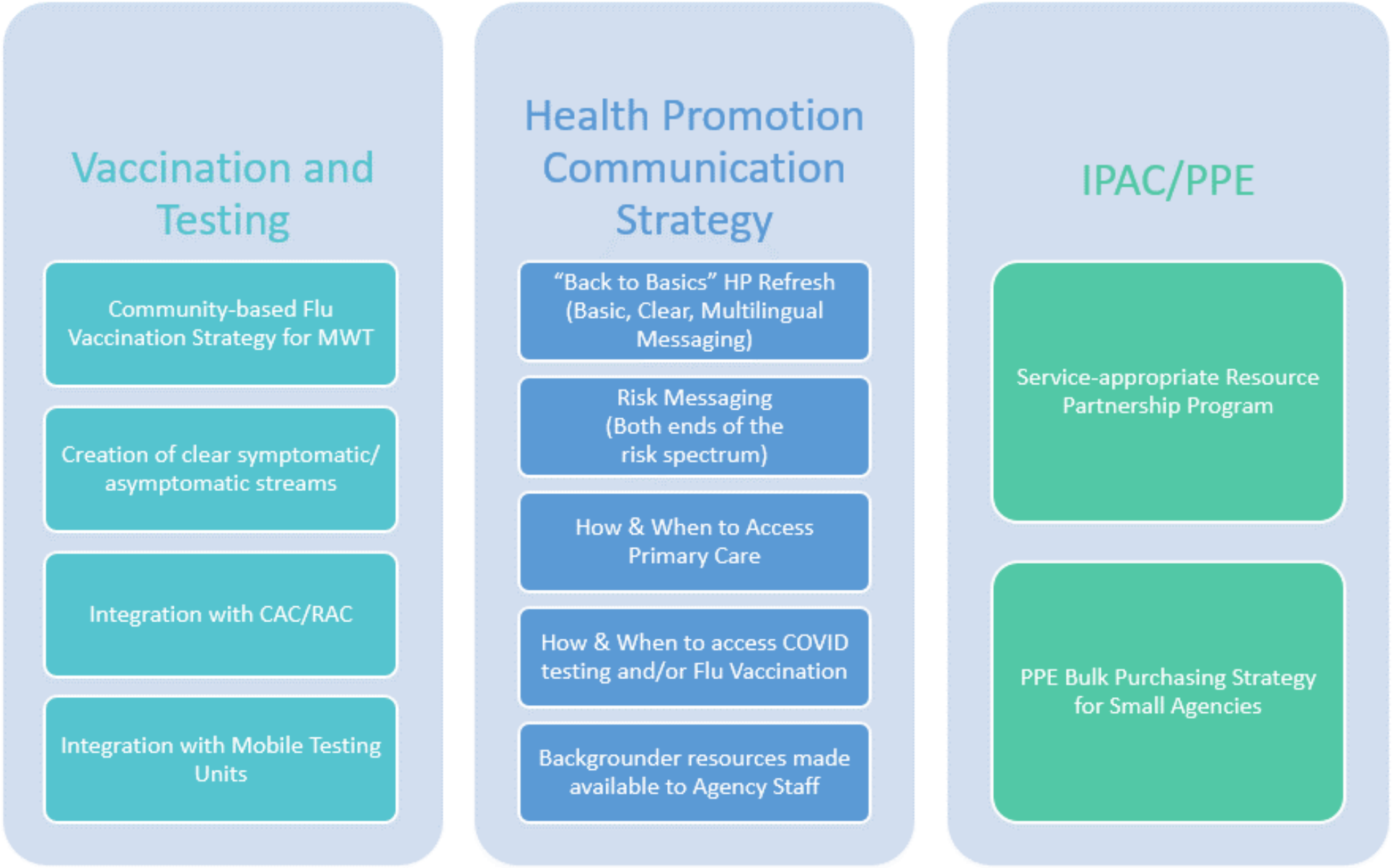
10. Conflict Management

At W2F conflict with be addressed with the person(s) directly; if no solution is found we will:

- Seek the guidance of the Chairs; if no solution is found
- Involve the Chairs of the Partner Table

Appendix 6 - Mid-West Toronto OHT

COVID-19 Wave 2/Flu Season Coordinated Response Working Group (W2F Working Group)
Planning Framework



Appendix 7
Mid-West Toronto OHT Patient and Caregiver Engagement Strategy

Engagement

There are multiple opportunities for people with lived experience to participate in the MWT-OHT

a) Become an Outreach Lead: Join the Design Project #1 Exploration Team and participate in the process of going out and talking to people about their experiences making observations. Many of these conversations will involve meeting people where they are and therefore locations will be vary. Time commitment is approximately 4hrs per week for between 3 to 4 months.
b) Become a Design Project #1 Advisor: Join a bi-weekly check in group that will define the questions that we are asking and provide input on the design process on a regular basis.
c) Become a Service Design Working Group Member: Join the Service Design Working Group that will meet approximately monthly and be responsible for inter-intra project and dependency management. The Service Design Working Group will also oversee project risks and implementation. Attendance can be dependent on agenda topic.
d) Share your experience or insight: Share lived experience stories or insights by participating in one-on-ones, focus groups, phone calls, etc.
e) Volunteer for the MWT-OHT Partner Table
f) Volunteer for the Executive Project Advisory Committee (EPAC): EPAC is the steering committee for the MWT-OHT and serves recommendations to the Partner Table on the strategy and planning process for OHT development. EPAC meets approximately monthly.

Remuneration

There are two different payment structures depending on nature of involvement:

1) Peer Advisors who regularly participate in the Service Design Working Group process will be paid an hourly wage for their involvement.

2) Individuals and Caregivers with lived experience who participate in interviews, focus groups or any other single session will be paid a set rate in cash; will be provided with a meal; and a TTC token.

Recruitment

Individuals and Caregivers with Lived Experience will be recruited for the above opportunities in one of two ways:

1) Direct invitation by committee or working group
2) Recruited with support from partner agencies and organizations

Willing participants will be given information on the nature of their involvement as well as the remuneration available to them prior to engagement.

Patient partnership opportunities will be varied and barrier-free to encourage participation from a truly representative cross-section of our population. Compared to the TCLHIN average, individuals in Mid-West are more likely to have less education, require transportation, have no knowledge of English or French and receive mental health and substance use support; potential barriers to traditional partnership approaches.