NORTH YORK FAMILY HEALTH TEAM

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Expanding and Enhancing Interprofessional Primary Care Teams

2023-2024

Expression of Interest

May 2023

Ontario Health

Ontario

Introduction

Your Health: A Plan for Connected and Convenient Care includes a commitment to connect more people with primary care in communities across the province, including additional funding to create more interprofessional primary care (IPC) teams to help make care more convenient for people. The Government of Ontario is taking immediate action to move forward with a process to expand existing teams and/or create up to 18 new teams in communities with the greatest need.

These multidisciplinary care teams will provide direct care to vulnerable and marginalized people as well as those without a family doctor across Ontario. This will help connect people to care when they need it without having to visit emergency rooms and experience long wait times, while also improving health outcomes by increasing preventive care and screening procedures.

Completing an Expression of Interest is a requirement for funding consideration by the Ministry of Health (ministry). The EOI should set out a convincing case or rationale and include all relevant details to enable the ministry to appropriately assess the need and effectiveness of the proposed programs and services in the community.

The ministry and Ontario Health (OH) are working together to manage the application process. Ontario Health will work with local primary care and community partners to support proponents' EOI applications.

Completed EOIs should be submitted to the relevant OH region at the contacts below by **5 pm Eastern Daylight Time, June 16, 2023**. Completed EOIs can be submitted by e-mail **to the corresponding regional contact (below)** in PDF or Microsoft Word format **using the following subject line**: *(Name of Applicant) EOI – Interprofessional Primary Care*.

Applicants are encouraged to seek assistance via the designated regional contact if they have difficulty preparing or submitting electronic applications.

OH Region	**Contact for submission**
Toronto	OH-Toronto.Funding@ontariohealth.ca
East	OH_East_IPC_EOI_Submissions@ontariohealth.ca
West	OH-West-PCEOI@ontariohealth.ca
Central	OH-Central_PrimaryCareAdvancement@ontariohealth.ca
North East	OH-NE-Finance@ontariohealth.ca
North West	OH-NW-Submissions@ontariohealth.ca

If you experience technical difficulty with the form, please contact your OH region using the e-mail above for assistance.

You are encouraged to answer each question clearly, completely, and concisely. Incomplete submissions will be evaluated according to the information provided.

You may resubmit completed EOIs until the closing date, but it is your responsibility to ensure that your OH region is aware of the new submission to ensure the most up-to-date EOI is evaluated.

You must:

- Ensure that the EOI is complete before submitting it to the OH Region.
- Affix any supporting or additional documentation in clearly defined appendices at the end of the EOI. Please include all copies of signed supporting documents.
- Ensure all supporting material is submitted by the closing date. Supporting material received after the closing date will not be considered.

The government is committed to enhancing equitable access to primary care and further strengthening the integration of primary care and other services, leading to connected care and improved patient experience. The creation or expansion of IPC teams aligns with ongoing efforts to strengthen primary health care as the foundation of the health care system in the province, ensuring Ontarians receive the right care in the right place. Accordingly, the ministry and Ontario Health are requesting proposals that demonstrate alignment with the following principles:

- Increasing access to care for unattached patients, patients with poorer health outcomes/health status.
- Ability to provide care to equity deserving populations with a demonstrated focus on reaching patients with poorer health outcomes.
- Efficient, effective and skills-based governance.
- Team based models of interprofessional primary care that maximize efficacy, scope of practice and how the team works together.
- Integration and collaboration with the broader health care system, including through Ontario Health Teams, as well as a commitment to participate in population-based planning for health service delivery.
- A commitment to using available data and evaluation for continuous quality improvement.
- The use of digital health to support care delivery and provide Ontarians with choice in how they interact with the health care system.

The ministry and Ontario Health will use an evaluation process, including criteria to assess for equity to review and assess EOI submissions. Based on the evaluation framework, the ministry will make recommendations for funding approval to expand and/or create IPC teams.

Disclaimer

It is the applicants' responsibility to ensure that all information provided is up-to-date and correct to the applicant's best knowledge and that the EOI reaches Ontario Health on or before the closing deadline. Ontario Health will support applicants in this effort. The ministry and Ontario Health are not responsible for EOIs that are lost, delayed, misplaced, or misdirected.

It is also the responsibility of applicants to ensure that all necessary legal and financial advice to complete this EOI is sought, if applicable.

By submitting an EOI, you acknowledge that this is not a competitive procurement/tender and that the recommendation of successful applicants for further funding shall be made at the ministry's sole and absolute discretion.

In reviewing EOIs, the ministry reserves the right to discuss and disclose the contents of such applications within the broader public sector and the applicants; and by submitting EOIs, expressly consent to such disclosure in addition to the following consent.

Consent

The ministry frequently receives requests for the release of contact information. The requestors for this information include individuals or organizations such as health care providers looking for jobs in family care practice models and media enquiries.

Consistent with the ministry's desire to protect the privacy rights of IPC team applicants, contact information will not be released to the public during the application stage. Once successful partners are announced, the ministry will only release the contact information of the successful IPC teams. The information will only be provided to individuals and organizations who have requested the same.

Interprofessional Primary Care (IPC) Team EOI

SECTION 1: ABOUT YOU

This section provides your organizational contact information and confirms whether the application is to create a new IPC team or to expand one or more existing IPC team(s). It also confirms the type of IPC team model proposed. For successful applicants, the information in this section may be released to requesting individuals or organizations with prior consent (as outlined in the "Consent" section of page 3).

1.1 Applicant Information

This section should be completed with information on the community applicant leading the creation or expansion of an IPC team.

Name of Applicant / Organization	North York Family Health Team Inc.
Location of Applicant / Organization	240 Duncan Mill Road, North York, ON, M3B 3S6
Name of Primary Contact/ Lead	Neil Shah
Title	CEO/Executive Director
Mailing Address of Primary Contact	240 Duncan Mill Road
City / Town	Toronto
Postal Code	M3B 3S6
Phone	647-260-1444
E-Mail Address	nshah@nyfht.com
Name of the Ontario Health Team the applicant is or will be part of	North York Toronto Health Partners

Please indicate whether the proposal is for expanding an existing team (adding new team members, adding a satellite location) or creating a new team, and please identify the proposed IPC team model i.e., Family Health Team (FHT), Nurse Practitioner-Led Clinic (NPLC), Community Health Centre (CHC), Indigenous Primary Health Care Organization (IPHCO) or Other.

	Proposed Model of IPC Team (FHT, NPLC, CHC, IPHCO or Other*)
X Expansion of an existing IPC Team	Family Health Team
☐ Creation of a new IPC Team	

*If the proposal is for a new model of care, please describe.

1.2 Governance Structure

Please describe the existing or proposed governance structure for the expansion or creation of an IPC team, including incorporation status, board composition, engagement of patients, people with lived experience, community members, and community partners and other relevant information about the existing or proposed governance of the IPC team. If this EOI is for the development of an IPC team outside of the current models (FHT, NPLC, CHC, IPHCO) and is not incorporated as a not-for-profit corporation, please describe the organizational structure of the proposed recipient of funds in full.

Applicants are encouraged to leverage an existing governance structure rather than create a net new structure. You may include an organizational chart detailing the structure of the new or existing IPC team.

e.g., You may include a description of any sub-committees of the Board, the member selection process, terms, evaluation processes and patient and family contribution.

This model is being put forward by the North York Toronto Health Partners (NYTHP), through a partnership with the team-based primary care organizations in our region. North York Family Health Team (NYFHT) will act as the lead agency, and contributing partners include Flemingdon Health Centre, Unison Health & Community Services, Vibrant Healthcare Alliance and the University of Toronto's Department of Family and Community Medicine (DFCM) at North York General Hospital. Together, along with our other OHT partners, we have developed and will implement the expansion of team-based primary care to everyone in our attributed population. Our vision is for compassionate team-based primary for all. Our model is based on the principle of inclusion. Everyone should have the best care and team-based primary care is the best type of primary care. This proposal will outline our vision of a collaborative model that aims to bring primary care attachment to 12,000 individuals in our region.

About the Lead Agency:

North York Family Health Team Inc. is a not-for profit incorporated entity with charitable status. The expansion team will operate under the governance of the NYFHT Board with relation to our OHT's governance structure. See Appendix A for NYFHT's Governance and Organizational Chart and NYTHP's Structure. The NYFHT's CEO actively participates the in OHT's governance structures as a member of the Stewardship Council and Co-Chair of the Operations Committee. The Medical Director is Co-Chair of the Primary Care Network and member of the Operations and Stewardship Committees.

NYFHT Board Composition:

- Four to six community members with skills outlined in skills matrix
- One Director shall be appointed from each Family Health Organizations in the MOH-FHT Agreement
- Chief of Family Medicine of the North York General Hospital (ex-officio)
- Each member sits on the Board for a three-year term, renewable once

NYFHT Board Committees:

- Governance and Nominating
- Quality
- Finance and Audit
- Research and Education

Board Member Nomination Process:

- Nominating committee conducts a review of skills matrix annually and targets through a public posting for open positions to identify potential candidates to fill vacant seats for presentation at the AGM.
- For details see Appendix B: Policy - Director Recruitment and Nomination

Engagement of patients, people with lived experience, community members:

- Patient Advisory Collaborative (PAC) - consists of 8-12 individuals (patients, family members, care providers, and/or community members) who are consulted and engaged by NYFHT on various matters to enhance and improve collaboration and the patient experience.
- The PAC Resource Pool consists of individuals (patients, family members, care providers, and/or community members) who are interested in participation but do not sit at the PAC due to time constraints or other factors. These individuals are invited to participate in projects, as needed, based on their interest, skill set, and ability to commit to the project timeline. For example, advisors with an interest in communications were recently asked to be part of a task force with this focus
- Patient surveys are always available and, from time to time, NYFHT surveys patients on specific topics. There were 2,600 responses to a targeted survey for our recent strategic plan.
- For details see Appendix C: Patient Advisory Collaborative – Terms of Reference

Engagement of community partners:

- We are a founding and leading member of the North York Toronto Health Partners. A list of all partners can be found here: https://www.northyorktorontohealthpartners.ca/our-partners
- Partners meet monthly as part of the OHT's Stewardship Council to discuss how to advance the OHT's mandate, shared purpose, priorities and accountabilities, as well as review any pressing system issues to work on collaboratively.
- As an organization, partner engagement is also completed regularly for specific initiatives. For example, with the recent development of the strategic plan, partner interviews and surveys were conducted to garner insight and feedback.

1.3 Team Composition and Model

Please complete the table below to identify the proposed/net new interprofessional primary health care providers (including identification of the most responsible primary care providers for the patients), as well as any specialists, if appropriate, that will be

affiliated with the IPC team, including their role(s). You also can add provider type under 'other.' Where applicable, attach a letter from the primary care physician, physician group, or nurse practitioner and any individual specialists confirming their commitment to join the IPC team.

Interprofessional Primary Care Provider Type	Proposed FTE	Description	Letter of Commitment Attached *(Yes/No)*
Physician or Physician Groups	1.5 (Salaried MDs for CHC) Community Primary Care Providers who are members of the PCN – goal is for all providers to be part of the fully expanded team	MRP for primary care programs Physicians will take on unattached patients	Yes, Commitment letter from FHC Yes
Nurse Practitioner	11.0	MRP for primary care programs	Commitment letters from CHCs and endorsed by NYFHT

Interprofessional Primary Care Provider Type	Proposed FTE	Description
Traditional Wellness Practitioner		
Registered Nurse	92.0	RNs are the heartbeat of team-based primary care. Their broad scope allows them to be the first line of defense for almost all patient encounters. This includes physical and mental assessments, diabetes and complex disease management, system navigation, counselling, care coordination and referrals.
Registered Practical Nurse	10.0	Similar to RNs, RPNs support the model of care delivery with the routine practices in primary care that RNs are equipped to provide.
Pharmacist	6.0	Pharmacists add capacity in team-based primary care models with their scope, and more recent added scope of practice. Their advance training and knowledge allow them to independently conduct research and

Interprofessional Primary Care Provider Type	Proposed FTE	Description
		give guidance to providers on care practices.
Psychologist	2.0	Psychologists will add capacity through diagnosing more complex mental health conditions and providing overall support to the mental health team.
Psychological Associate		
Psychotherapist		
Mental Health / Social Worker (BSW)		
Social Worker (3 yrs. Exp + MSW)	36.0	Social workers will support the mental health needs of patients and are a highly-used service.
Dietitian	15.0	Dietitians will lead the counselling support in our nutrition-based programs, plus support patients with complex conditions such as post-cancer treatment, seniors, or individuals going through a transition in their health status.
Health Educator/ Promoter		
Respiratory Therapist		
Chiropodist	4.0	Support the required foot care, especially of our seniors.
Case Worker / Manager	7.0	Add capacity to our mental health team through direct patient care in system navigation and coordination.
Occupational Therapist	4.0	Support the required physical care, especially of our seniors, and facilitating how to keep individuals living at home and out of institutional

Interprofessional Primary Care Provider Type	Proposed FTE	Description
		care like hospitals or long-term care homes.
Chiropractor		
Physician Assistant		
Physiotherapist	4.0	Support the required physical care, especially of our seniors and those with complex physical concerns.
Kinesiologist		
Midwife	5.0	Add capacity to our existing primary care providers by taking on the care for pregnant people, including post delivery.
Care Coordinator / System Navigator	3.0	Will support our patients navigate the system by connecting them to right level of care and offering this support in culturally appropriate ways translating the system to them in a way they can understand.
Community Ambassador	5.0	Conduct the necessary outreach into our communities to identify and attach patients in need and bring the voice of the patient/community to planning tables, complementing our patient advisory roles.
Other: (specify)		

Management/ Administration	Proposed FTE	Role (e.g., consultation, program delivery)
Executive Director		

Office Administrator / Manager	5.0	Clinical lead to support allied health providers with practice delivery and manage growth in team
Human Resources support	3.0	With the expanded team, this role adds capacity for the team and support for leaders to support our people, which will contribute to retention
Finance Manager	2.0	This role will ensure financial practices are maintained, while also supporting processes, policies and other corporate functions like risk, privacy, procurement and facilities management.
Program Administrator	5.0	In partnership with the Manager, the Program Administrator supports the on-the-ground implementation of programs, ensuring physician engagement and participation.
Clerical / Receptionist	14.0	These roles support patients to get the right appointments and can speak their language as needed. They also support patients and their families when they arrive in our clinics and ensure health provider appointments and processes run efficiently.
IT Support vs purchase of service	2.0	With the size of the team, it would be most effective to have a dedicated role to guide, support and lead the implementation of digital tools. Having one point person with the technical knowledge of our systems and the EMRs used by the various providers will help ensure smooth day-to-day operations of moving patient information between providers.
Data Specialist	3.0	This role will ensure we can support measurement, reporting on outcomes, data standardization and

		connect our community physicians to digital tools.
Other (please describe) Quality Improvement Specialist	2.0	This role is key to spread leading practices and quality standards across additional sites as well as. lead patient advisory work.
Other (please describe) Director	2.0	Directors are required to oversee the management of clinical programs as we expand to cover a larger patient population.

Specialist Type	Proposed FTE (# of 3-hour sessions)	Role (e.g., transfer of care/consultation)	Letter of Commitment Attached *(Yes/No)*
Note: Please add more rows as needed.			

1.4 Primary Care Model

Please describe how the IPC team will work together in this model including with non-IPC team primary care providers (i.e., family physicians unaffiliated with the IPC team, community pediatricians, pharmacists, and nurse practitioners) to:

1. Provide attachment and comprehensive primary care for currently unattached patients.
2. How the model will maximize the scope of practice of the various interprofessional providers.
3. Whether the IPC team supports future practitioners and those new to practice.

Please also describe how care delivery by the IPC team will be organized (co-location, virtual, mobile, common EMR / information sharing) to maximize efficacy, team integration and reach.

This expanded team can be implemented quickly as it would be scaling up the operations and service offerings in established healthcare organizations in the community with proven records for quality, efficient care, with roots in supporting diverse communities and the most marginalized.

1. How the IPC team will work together in this model including with non-IPC team primary care providers (i.e., family physicians unaffiliated with the IPC team, community pediatricians, pharmacists, and nurse practitioners)

- The goal of this expansion proposal is to bring team-based care services to all individuals in our region. This includes connecting with existing and with new primary care providers in our region. Our model is based on the principle of inclusion. Everyone in our catchment should have access to the best primary care, and team-based care is the best model for patients, providers and the health system.
- With this model in place, all of the team-based care providers in our OHT will work collaboratively to implement this model. We will work together as one team in a connected fashion to ensure patient care is convenient and easy to access for our population. In this bold model of collaboration, our strength comes from working together across our models, and bringing in all our OHT partners to wrap care around our population.
- Our first priority will be those in our identified highest need neighbourhoods and who are underserved. Need is based on high percentages of immigrant and visible minority populations, a larger number of seniors, higher rates of low-income households and higher unemployment rates.
- All identified highest needs individuals would receive the care and support they need through access to team-based care.

2. Providing attachment and comprehensive primary care for currently unattached patients.

- Our model is based on comprehensive primary health care that is embedded in the Model of Health and Wellbeing and rooted in the belief that health is a state of the best possible physical, mental, social and spiritual wellbeing.
- This means offering primary care services in combination with health promotion, prevention, and community development activities to address the social determinants of health and providing care from an anti-oppressive, anti-racist and health equity lens. This includes not only addressing medical and biological issues, but also improving the circumstances in which people live, work, play and age.
- Comprehensive primary health care not only improves the health of individuals, but it also creates healthier communities – inclusive, connected and caring places where everyone feels they belong and are empowered to take control of their health and wellbeing.
- Our OHT is working to identify unattached individuals through Health Care Connect and our Community Ambassadors who work in the community and can identify individuals who need regular primary care. We can initially connect these individuals with the allied support they need through the IPC team while they wait to be connected to an appropriate regular primary care provider. Our NP-led clinics can also provide access to care for those with complex needs including seniors, homebound individuals, and those with mental health needs and cancer.

- With the investment outlined, we can bring attachment to 12,000 patients in our region, many of whom are classified as complex – for instance have a physical disability, mental health condition, cancer, multiple chronic diseases etc.
- We have a history of doing this and our populations served are already more complex than the provincial average. According to our SAMI scores, while the provincial average is 0.97, our scores are:
    - FHC: 1.57
    - VHC: 2.2
    - UHCS: 1.67
    - NY-DFCM: 1.11

  This means that our clients are more complex than the average person in Ontario and are expected to require more primary care. Our plans will continue to build on this approach to ensure we target those who need our care the most.

3. How the model will maximize the scope of practice of the various interprofessional providers.

- With a full complement of diverse team members, each practitioner will be able to work to the full scope of their practice
- For example, with nursing and dietitian support, nursing can act as the first line of contact for nutrition-based conditions. For those patients with complex conditions or who require a more extensive work-up and counselling, the patient can be introduced to the dietitian who can work with the patient to create a plan, and once on track, the nurse or physician can resume regular follow-ups on their primary care visits. Working as an integrated team allows us to easily connect to one another, ensuring the patient gets the right level of care when they need it.
- Although assigned an MRP (physician or nurse practitioner), the team-based model also ensures a patient will always receive care, even if their MRP is away.
- Today, nurses in the North York Family Health Team work to their full scope of practice, providing a first line of contact for most patients, continuing to care for patients with counselling, and connecting patients to other members on the health team. These patients include those seeking wellness care, and those with complex conditions that require additional assessment and follow-up. Appendix D outlines the roles and responsibilities of nurses in the FHT, which demonstrate the robust nature of this role.
- Appendix E includes job descriptions for many of our existing allied health providers on the team outlining how they work to their full scope of practice and contribute to advancing primary care in a team-based model.

4. Whether the IPC team supports future practitioners and those new to practice.

- Our goal is to include all practitioners in our region – our expanded team will continue to support future and new practitioners as it has for the past 15 years.
- The Department of Family and Community Medicine at NYGH is the largest community-based teaching site in Canada. Learners work right in the community and alongside our team-based models. Therefore, all trainees in our community learn how to work in an interprofessional model, and when they choose to practice

in one of our neighbourhoods, they will be brought in to practice in the team-based model.
- Interprofessional team members also serve as preceptors for a variety of students from nursing, social work, dietetics and more
- We have a history of growth. For instance, FHC supports clients of community physicians – including those new to practice – by providing interprofessional team services and community programs to all residents of their catchment area. When NYFHT started, there were 48 physicians working in partnership with the FHT. Today there are 94. This practice will continue with the added investment to ensure all patients have access to team-based care. Appendix F demonstrates this growth from 2008 – 2023.

5. How will the care delivery by the IPC team be organized (co-location, virtual, mobile, common EMR / information sharing) to maximize efficacy, team integration and reach?

- As well-established organizations, we currently provide care out of our central offices and co-locate care in our physician partner offices. These locations include:
    - 240 Duncan Mill Road
    - 5 Fairview Mall Drive
    - 2398 Yonge Street
    - 540 Finch Avenue West
    - 12 Flemington Road
    - Plus, see Appendix G for a map of existing physician office locations in North York.
- This practice will continue as the team expands. We will continue to build practices out of our existing offices, and working with physician offices, providers will be co-located where patients know how to access care. As we cover such a large geography, we understand that patients have identified their provider based on how they would like to access care.
- All programs also have a virtual offering to increase access and patient satisfaction.
- Each of our teams will be connected to a single EMR which can be accessed anywhere. Where providers need to access a partner physician's EMR, VPN or cloud-based access will be established to ensure the provider has full access to a patient's chart. Physician-FHT agreements establish privacy and circle of care standards for this to take place. For initial contacts, Ocean e-Referral will be leveraged to ensure the sharing of appropriate information and secure messaging between providers. This is the model we currently employ, and we would continue to expand it as more providers come online.

1.5 Ontario Health Team (OHT) and Community Partnership and Collaboration=

It is strongly encouraged that applicants partner with the local Ontario Health Team (OHT), depending on OHT maturity, and obtain a letter of commitment for that partnership. If you are not part of an OHT, please describe plans to partner with other

individuals, groups, or organizations (including home and community care providers, educational institutions, health service agencies, pharmacies, public health units, mental health and addictions organizations or municipalities) in the community to organize the delivery of services to the community and prevent duplication of services, if applicable. As identified, the ministry and OH are continuing to work with First Nations, Inuit, and Métis and urban Indigenous partners to ensure we are taking the most appropriate approach to addressing specific challenges and unique needs throughout the province. For Indigenous Primary Health Care Organizations (IPHCOs) not presently engaged in OHT activities, please provide a detailed rationale and response regarding efforts undertaken to build partnerships across the continuum of care. This will help the ministry and OH better understand challenges and unique needs when assessing applications.

It is also encouraged that applicants include a letter of support from their respective municipality. See section 2.3 for more information on what elements should be part of the discussion with the OHT. Please complete the following table for each service partner, adding more rows as needed.

Name and Contact Information of Partnering Organization	**Describe the Planned Collaborative Service Delivery**	**Letter of Commitment Attached *(Yes/No)***
Unison Health & Community Services	Unison will be partnering with NYTHP to support access to primary care services for equity deserving populations such as those experiencing low income and who are newcomers to Canada.	Yes
Flemingdon Health Centre	Flemingdon will be partnering with NYTHP to support access to primary care services for equity deserving populations such as those experiencing low income and are newcomers to Canada.	Yes
Vibrant Healthcare Alliance	Vibrant will be partnering with NYTHP to support access to primary care services for equity-deserving populations, such as those experiencing low income,	Yes

	those with physical disabilities and newcomers to Canada.	
Freeman Centre for the Advancement of Palliative Care (NYGH)	The Freeman Centre will leverage its NP-led primary care team to provide care for patients with palliative and supportive care needs	Yes
CMHA-Toronto	CMHA Toronto will leverage its NP-led primary care team to support residents with mental health and addictions care needs	Yes
Baycrest Inter-professional Care Team (IPCT)	Baycrest will launch a new IPCT team	Yes
Home and Community Care Support Services (HCCSS) – Central	HCCSS-Central will partner to support primary care teams with access to home care services	Not able to
Department of Family and Community Medicine (DFCM) – NYGH at the University of Toronto	The DFCM-NYGH will provide capacity for primary care by supporting learners and residents.	Yes
Circle of Care	Circle of Care will support the implementation of home-based primary care teams	Yes
VHA Home HealthCare	VHA will support the implementation of home-based primary care teams	Yes
North York General Hospital	NYGH will support the development and implementation of expanding team-based care and build primary care bridges with hospital services	Yes

Closing the Gap Healthcare	Closing the Gap will support the implementation of home-based primary care teams	Yes
Bayshore HealthCare	Bayshore HealthCare will support the implementation of home-based primary care teams	Yes
SE Health	SE Health will support the implementation of home-based primary care teams	Yes

1.6.1 Community Consultation and Co-Design of Programs and Clinical Services

Please describe community consultation activities that demonstrate the application has the support of community partners and planned mechanisms for ongoing co-design of programs and clinical services with community partners.

Please provide details of consultations with different community groups including those that represent a variety of populations (i.e., Black, Indigenous, Francophone and other racialized communities, community partners that serve clients with disabilities or experiencing homelessness, newcomers etc.).

Consultations that have taken place to inform prioritizing resources, tailor offerings to areas of highest need, and gain support of community partners

Community partners were consulted in the early stages of EOI development to ensure that services and connections included in the application reflect local priorities. Gaps were identified through informal discussions at local inter-sectoral tables, which included both front-line and leadership staff from health, social service, and community organizations/groups (e.g., faith leaders, settlement agencies, neighbourhood associations). These consultations included:

- Debrief with 14 North York Vaccine Engagement Team Community Ambassadors on May 5. Ambassadors represent a range of ethnic, racial, linguistic, socio-economic, age, and geographies in North York.

- Consultation with Bathurst-Finch Hub partners on May 17; EOI parameters were discussed, and partners provided feedback on Bathurst/Finch neighbourhood needs concerning access to team-based and primary care. Partners from the Bathurst-Finch hub who were included in the consultation: CUAS Immigrant Services, Downsview Community Legal Services, JVS Toronto, Kababayan

Multicultural Centre, North York Community House, Toronto Public Library, Centennial Branch, and Unison Health & Community Services

- Consultation with North York Cluster table on May 24. Members expressed support and interest in the proposal and looked forward to learning more. Conversation kicked off with targeted questions to solicit information on care gaps experienced by clients of these agencies and understanding of support for the EOI. At a follow-up Consultation on June 14, 2023, partners expressed universal support and enthusiasm for the collaborative efforts of the OHT to craft a detailed plan to expand care access in North York. Partners included in the consultation included: Mennonite New Life Centre, Toronto North Local Immigration Coalition, Jewish Child & Family Service, Willowdale Community Legal Services, Neighbourhood Link, Jewish Immigrant Aid Society, Bernard Betel Centre.

These three early consultations revealed consensus that communities in North York, particularly newcomers and racialized and/or non-English speaking communities, experience gaps in access to mental health care, food security, and supports for families with young children and seniors living alone. In addition, primary care attachment as well as access to primary care after hours and on weekends were highlighted as areas of need across North York.

- Our proposal team is leveraging earlier data and reports shared by partners to inform the proposal and to identify gaps referenced in other sections of this application. Examples include:

    - Toronto North Local Immigration Partnership (TN-LIP) shared a report on racism and newcomer access to health services in North York which sheds light on barriers to care experienced by newcomers
    - The NYTHP Community Health and Information Fairs (CHIFs) included an iterative evaluation component in which post-fair surveys were given to participants and partner agencies. The data from those surveys also informs our understanding of ongoing community needs in priority areas of North York.

Planned mechanisms for ongoing co-design of programs and clinical services with community partners.

The applicants for this EOI have embedded community feedback and co-design into our ongoing programs across North York and the OHT and would extend those community engagement mechanisms to any programs and/or clinical services launched resulting from this EOI. These include:

- Regular check-ins with North York Community Ambassadors in an advisory capacity to understand local needs and problem-solve challenges faced by residents in being connected to services and attached to primary care.
- Recurring check-ins with standing community tables such as the North York Cluster, Fairview Inter-Agency Network, North York Local Immigration Coalition, and Bathurst-Finch Hub. These collectively represent over 40 community partners

and agencies serving clients and communities in North York, with a focus on reaching and serving marginalized and equity-deserving residents. NYTHP has a regular presence at these tables and dialogue is ongoing. There is a standing agenda time at recurring meetings for the OHT to bring questions or raise discussion items, and many of the agencies at these tables are also Core or Alliance NYTHP partners collaborating on a number of key initiatives. All of these tables as well as the NYTHP Communications and Engagement Committees are able to cascade future engagement efforts across the clients/patients/communities served by any and all of the partners at these tables.

- North York Toronto Health Partners is itself made up of 21 Core and over 30 Alliance partners from across the health and social service sectors. Regular meetings of the NYTHP Stewardship Council, Operations Committee and the Backbone represent recurring checkpoints at which new and prospective programs and care redesign are discussed and refined.
- Our standing NYTHP Patient and Caregiver Health Council (PCHC) and NYTHP Primary Care Advisory Council (PCAC) include mechanisms to continually engage and co-design with the communities and patients/caregivers who we collectively serve as providers (see Section 1.6.2).

Given the widespread support from and history of regular collaborative opportunities with our numerous community partners, we are well positioned to continue co-designing programs and clinical services. By expanding team-based care, including through clinical pathways, all partners are made aware of opportunities to contribute to program development.

1.6.2 Patient, Family, Caregiver Consultation in the Community and Co-Design of Programs and Clinical Services

Please describe patient, family and caregiver engagement activities done within the community that demonstrate the application has the support of patients, families and caregivers and planned mechanisms for ongoing co-design of programs and clinical services with patients and families.

Describe engagement activities done to demonstrate application has the support of patients/families/caregivers

The parameters of the EOI were brought before the full NYTHP Patient and Caregiver Health Council (PCHC) at their monthly meeting on May 31 for discussion and feedback. All members of the Council were invited to review the written content of the EOI and provide feedback and edits, as well as join planning calls with the applicant organizations. Further to that consultation, the NYTHP-PCHC has submitted a written Letter of Support.

To consult with additional patient/caregiver advisory tables who were unable to join a consultation event, we developed a written survey with input from our embedded evaluation scientist that was shared across all partner applicant organizations. This survey summarized information about the EOI application and sought to gain a better

understanding of patient/caregiver interest in the plan as outlined, including feedback on primary care needs. Patient and Client advisory tables of our North York CHCs, Family Health Team, and the NYTHP-PCHC were all invited to respond to this survey. The results of the survey include:

- 100% support rate for the EOI's approach to expanding team-based care.
- Additional primary care and social care services identified as needed in the community included care for the elderly, food supports, access to mental health care, interpretation services, and culturally sensitive care.

Vibrant Healthcare Alliance discussed the survey with their patient, family, and caregiver members during an in-person group engagement meeting on June 13, 2023. They consulted with clients of their barrier-free clinics, seniors, and volunteers. Overarching consensus from the consultation was support for the EOI's expansion of team-based primary care. Other results of the consultation included:

- Consensus on the need for timely access to quality allied health services.
- Consensus on the need for culturally competent PCPs who have experience serving complex clients/patients.
- Desire to be able to access care across the North York geography rather than being tied to one physical site.
- Community-based care settings were identified as low-barrier and preferred.
- System navigation was identified as a widespread need.

These engagement activities affirm the EOI goal of expanding team-based care to all in North York, recognizing that a team-based approach is needed to address primary care issues that matter to local residents, and to address social determinants of health within community-based care settings.

Planned Mechanisms for Ongoing Co-Design

NYTHP PCHC members sit on every Committee of the OHT, including the Primary Care Advisory Council (PCAC), embedding the patient and caregiver perspective at all levels and stages of program design, implementation, and evaluation, and co-creating the priorities that drive OHT activity. Primary care-focused initiatives are co-designed with patient/caregiver partners who bring lived experience to the programs. PCHC and other community members are involved in co-design of NYTHP's initiatives and share their lived experience and expertise to shape how services are designed and delivered to our community with a focus on equity, diversity, and inclusion. We will leverage these existing processes and organizational norms of patient/caregiver collaboration to co-design any services or clinical programs that arise as a result of the EOI.

The North York FHT as well as the two partner CHCs will leverage their PFACs and CFACs to promote patient and caregiver-informed programming, reduce health gaps and improve health outcomes amongst equity-deserving communities. As implementation of our expanded teams roll out, the most appropriate patient councils/ groups will be engaged to review program design and community feedback. Where needed, individuals of communities not represented will be added, or new

relationships will be formed with community-organized groups. We are committed to inclusion and will partner with our neighbourhood communities in the manner they prefer.

1.7 Physician Engagement

Please describe physician consultation engagement activities done that demonstrate the application has the support of physician partners. Proponents are encouraged to attach documentation such as letters of endorsement from physicians and/or physician groups consulted.

Primary care has been at the core of the NYTHP OHT since its inception in December 2019. Primary care has been integral in helping to guide the direction of the OHT through regular and ongoing engagement activities with the primary care community. Establishment of a formal Primary Care Network (PCN), with over 230 members, has allowed for two-way communication with our primary care community. In addition, further primary care governance was established with a Primary Care Advisory Council of elected individuals who bring the primary care voice at all OHT working groups and the Stewardship Council.

Primary care engagement has been regular and continuous from the beginning with activities including webinars, regular newsletters, in-person engagement events and in-office consultations.

The NYTHP Primary Care Association held a Connecting Care Event on October 13, 2022, bringing together our primary care community, specialist colleagues and OHT partners. Over 100 primary care and specialist providers and community were engaged on the opportunities and benefits of being part of our PCN. Through idea boards and informal feedback, we gathered participant's ideas and thoughts regarding gaps in care how future initiatives should be directed to meet their practice and patient needs.

Various themes emerged, which we continue to address and has helped to inform our EOI. These include increased mental health supports, improved communication with community service partners, reduced administrative burden, support with digital tools and with increasing cancer screening rates. Supporting care of the homebound and seniors' population overall were also highlighted.

Most importantly, increased access to team-based care was a theme that coursed through the entire session. In response, informal teams were established building on new connections made with community partners.

Our PCN holds many webinars to further engage the community and foster discussion on how our OHT can help meet patient care needs. The most recent was held on March 29, 2023.

We maintain a database of PCPs in our region that is continuously updated. This allows us to track PCPs involved in specific OHT initiatives (e.g., SCOPE, eReferral, OAB) so that we can market and reach out to those who are not yet involved. This database also allowed us to quickly reach out to a large number of community physicians across our area to inform them about our EOI for compassionate team-based care, seek input on our approach, and request their support.

Ongoing engagement continues with the “Breakfast with the PCN docs” where the primary care co-chairs travel to practices of primary care providers who are not yet part of the PCN to engage in discussions about local challenges and priorities to further inform OHT initiatives. The “Breakfast with the PCN docs” session on June 12, 2023, focused on the clinical practice needs of a particular neighborhood.

In addition, FHC’s Senior Leadership met with physician leadership and primary care providers to gain their input in the EOI application and support for the expansion of the team. The physicians and nurse practitioners are community leaders in serving equity-deserving populations and the physicians are affiliated with the University of Toronto Department of Family and Community Medicine (DFCM).

Meeting with Physician Leads
- Dr. Jennifer Kong, MD Lead - Fairview Site
- Dr. Lisa Ilk, MD Lead - Flemingdon Park Site
- Dr. Catherine Yu, Medical Director, Health Access Thorncliffe Park Site / Chair of East Toronto Family Practice Network
- Dr. Jan Krulewitz, former FHC-CHC Physician in Chief:

Meeting with all Primary Care Providers
- Dr. Dan Queen (Flemingdon Site)
- Dr. Kelly Grant (Flemingdon Site)
- Dr. Rucha Khandekar (Flemingdon Site)
- Dr. Lisa Ilk (Flemingdon Site)
- Dr. Denise Wong (Flemingdon Site, Health Access Thorncliffe Park)
- Dr. Rajani Vairavanathan (Flemingdon Site, Health Access Thorncliffe Park)
- Dr. Marina Aptekman (Flemingdon Site)
- Dr. Brenda Weitzner (Fairview Site)

- Dr. Jennifer Kong (Fairview Site)
- Anna Robinson, NP (Fairview Site)
- Nora Dixon, NP (Fairview Site)
- Dr. Meera Shah (Health Access Thorncliffe Park)
- Dr. John Ihnat (Health Access Thorncliffe Park)
- Dr. Catherine Yu (Health Access Thorncliffe Park)
- Dr. Elaine Cheng (Health Access Thorncliffe Park)
- Dr. Santosh Kanjeekal (Health Access Thorncliffe Park)
- Peggy Gerritsen, NP (Fairview Site)
- Rita Wong, NP (Health Access Thorncliffe Park)

SECTION 2: ABOUT THE COMMUNITY

This section describes the community(ies) in which the proposed IPC team will be located and provides information on the region, the availability of existing population-based health information, health care services, and the rationale for establishing or expanding an IPC team.

2.1 Population Health Status

Please describe the health status of the population the proposed IPC team will be serving. Include data about population size and demographics, including specific needs of the population, and social determinants that contribute to the health status of clients in the community(ies). Please describe population groups such as Indigenous and Francophone Ontarians, newcomers, racialized people or others, and the differing needs, barriers to equitable care access, and health status they may have that are relevant to this exercise.

North York Toronto Health Partners (NYTHP) OHT serves an attributed population of just over 500,000 distributed across 18 diverse neighbourhoods in North York and beyond.

Our focus for this section of the EOI will be on those who reside in our main geographic boundary. Our approach to care is based on neighbourhoods. This means that clients of the primary care providers, and anyone residing in the neighbourhood would gain access to team-based services. This includes patients attached to non-team physicians in the community who do not currently have access to comprehensive primary care. These services include foot care, mental health counselling, and nutrition services as well as participation in all community programs. This model centres people and communities and ensures ongoing engagement with socially and clinically complex patients. Appendix H includes a map our neighbourhoods.

Highlights of the health status of our population are described below. A summary table can be found in Appendix I. In Section 3.1 a detailed listing of the key characteristics to be addressed for each neighbourhood are outlined. This highlights the diverse needs the expanded team-based model would address, demonstrating why each of our neighbourhoods requires a unique community-based focus to address population health needs.

Our overall population of 500,000 is diverse, aging and growing.

- 17% of our population are seniors aged 65+ with some neighbourhoods (Bayview Woods-Steeles, 28%; Banbury-Don Mills, 25%; Hillcrest Village, 25%) having a disproportionately high number of seniors compared with the Toronto average (16%).
- We are also among the fastest-growing regions in the province with our top 2 neighbourhoods having a projected population growth of 77% (Henry Farm) and 71% (Bayview Village) (from 2017-2026).

Our diverse NYTHP population deserves inclusive, culturally appropriate, and language-accessible team-based care.

- 6/18 neighbourhoods are among the most ethnically concentrated in the province; newcomers/immigrants in our neighbourhoods range from 44-69% with 10/18 neighbourhoods being composed of >60% immigrants.
- Further, 14/18 neighbourhoods have >50% of residents who are racialized/visible minorities with 5 neighbourhoods being >70% racialized.
- 2016 Census data indicates that our main non-White ethnic populations are East/Southeast Asian, West Asian/Arab, South Asian, and Black, and that our top mother tongues are Cantonese, Mandarin, Italian, and Tagalog. We also serve a small Indigenous population (0.3%).

Our population has diverse health needs given wide-ranging social determinants that differ across our urban-suburban geography.

- 10/18 neighbourhoods have >20% of residents who are low-income (e.g., Willowdale East, 30%). 13/18 neighbourhoods have >10% of residents living in unsuitable housing (e.g., Henry Farm, 23%). Unemployment rates range from 6-10%, with 13/18 neighbourhoods being >8% unemployed (vs. Toronto's 8.2%).
- 5/18 neighbourhoods are made of >20% lone-parent families.
- Even within relatively affluent neighbourhoods, there is extreme income inequality with high levels of economic deprivation and marginalization amongst residents living along the main arterial streets, and concentrations of wealth inside suburban areas. Targeted, team-based strategies are needed to serve priority communities who live in higher-density housing along the main roads.

Expanding integrated team-based primary care is critical to meeting the health and social care needs of NYTHP communities given physician shortages.

- In 6/18 neighbourhoods, there were <5 physicians who provide comprehensive primary care (in 2017), and 6/18 neighbourhoods have a projected (in 2023) >30% service capacity at risk of loss due to retirement.
- 12/18 neighbourhoods' need for primary care exceeded capacity; this NYTHP shortage of primary care capacity is expected to grow by an additional ~240,000 yearly visits by 2026.

With expanded team-based care, NYTHP could increase patient attachment through our existing team-based models – NYFHT, and Flemingdon, Unison, Vibrant CHCs.

- 7/18 neighbourhoods are considered high-needs due to lower CHC and NYFHT utilization. Expanded team-based care would better serve our communities managing chronic conditions. 33% of our healthcare users have at least one chronic condition; 9/18 neighbourhoods have >10% of residents managing 4 or more health conditions, indicating complex health needs requiring a team-based approach.
- ~9% of our population has also used mental health services; however, there is not enough mental health resources - the emergency department is the first contact for mental health needs for 25% of residents.

Our Vision of "compassionate team-based primary care for all" will eventually connect the entire NYTHP population to primary care teams. We are well-prepared to begin expansion with priority neighbourhoods based on hyper-local needs.

2.2 Existing Primary Care Capacity

Elaborate where there are gaps in access to primary care, attachment rates and the provision of interprofessional care (i.e., existing primary care practices without access to IPC teams such as solo practices and some group practices). Please describe how the proposed model will support the integration and collaboration with existing primary care services and other community-based health care services available in the catchment area.

Primary care services may include Nursing Stations, primary care physicians, Family Health Teams (FHTs), Indigenous Primary Health Care Organizations (IPHCOs), Nurse Practitioner-Led Clinics (NPLCs), Community Health Centres (CHCs), hospitals, mental health and addictions services, community support services, Public Health Units (PHUs) etc.

Today, in our geography, team-based care is available to those patients connected to North York Family Health Team, North York residents receiving care through Vibrant Healthcare Alliance and Baycrest's IPC Team, and those receiving care through the satellite sites of Flemingdon Health Centre and Unison Health Care Services. This leaves most of our population without access to a team-based primary care model - approximately 400,000. Data from Ontario Health identifies 43,841 individuals who are uncertainly attached to primary care. With our wide geography, these individuals are scattered throughout our region. There are a few areas of clusters of uncertainly attached individuals – along the Don Mills corridor and Yonge St, both densely populated areas with newer condos. See Appendix J for maps of attached and unattached individuals.

The proposed model will leverage the power of our OHT to support integration and collaboration among existing primary care services and other community-based health care services in the catchment area. This proposal is a collaboration of all OHT providers, anchored on the strength of existing team-based models in our region, CMHA Toronto and the various home care providers. Through our model, providers will work together to wrap interprofessional care around our population. Whether teams can enhance an existing program or increase their existing presence in a particular neighbourhood, they will be leveraged to add resources and to do more. Our goal is for our population to have access to any team member in our region.

Based on available data, the attachment rate per neighbourhood ranges from 68% to 80%. We will use data to prioritize implementation and resources for our expanded model.

NEIGHBOURHOOD	PRIMARY CARE (PEM) ATTACHMENT (%)
Banbury-Don Mills	75.7
Bathurst Manor	72.2
Bayview Village	75.8
Bayview Woods-Steeles	78.9
Clanton Park	67.9
Don Valley Village	74.0
Henry Farm	70.6
Hillcrest Village	80.4
Lansing-Westgate	70.1
Newtonbrook East	77.2
Newtonbrook West	73.9
Parkwoods-Donalda	72.0
Pleasant View	76.2
St. Andrew-Windfields	73.1
Victoria Village	71.2
Westminster Branson	73.7
Willowdale East	74.3
Willowdale West	75.3

2.3 Strategic Alignment

Please describe how the planning, design and delivery of programs and services will align with key provincial and OH priorities; in particular, how the proposed IPC team will demonstrate and contribute to the following:

- Increase patient attachment to a regular source of primary care (enrolment to a family physician or registration to a nurse practitioner/primary care team).
- Reduce barriers to care for historically disadvantaged populations.
- Increase access to primary care through additional hours and/or days of availability.
- Efficient and effective governance (i.e., board operations).
- Team-based models of care that maximize scope and how the team works together.
- Integration and collaboration with primary care partners and Ontario Health Teams and participation in population-based planning and service delivery.

- A commitment to a learning health system philosophy (using data and evaluation for continuous quality improvement).
- Improve patient engagement (including diversity that represents the community served) and patient-centred care.
- Use digital health solutions to support care delivery.
- Support the principle of providing the right care in the right place.
- Be agile and responsive to the needs of the community over time and in crisis responses (including providing guidance or referrals to social service supports).

Link to NYTHP Strategic Plan:
https://www.northyorktorontohealthpartners.ca/strategic-plan

The planning, design, and delivery of programs and services for the expanded interprofessional team in North York is entirely in alignment with key provincial and OH priorities related to meeting the needs of communities served, advancing equitable, people-centred care and health system sustainability and improvement. The proposed expansion will demonstrate and contribute to the following:

1. **Increase Patient Attachment to a Regular Source of Primary Care**
   - The expansion aims to attach up to an additional 12,000 currently unattached patients in order to ensure they have regular access to a family physician or nurse practitioner as well as an interprofessional team. This attachment can start in as little as 3-6 months post investment (following the recruitment, hiring, and onboarding of new providers)
   - Patients will receive a full-team approach that allows them to build trusted relationships with various team members and seamlessly access another PCP, if their main PCP is away, at no penalty
   - Our CHC partners provide primary care services for those who do not have OHIP. Members of the community can be uninsured for a variety of reasons, such as newly landed immigrants, those eligible for OHIP who are precariously or under-housed, those that are non-status etc.
   - Leveraging an existing and expanded team of Community Ambassadors, a community outreach approach will be used to identify people without access to primary care and ensure equity-deserving groups are prioritized.

2. **Reduce Barriers to Care for Historically Disadvantaged Populations**
   - The team expansion builds our partners years of experience and expertise and long-established trust and relationships with the communities we serve.
   - There is a strong and demonstrated commitment to health equity
     - All members of CHCs' IPC team (including providers funded through this expansion) have a clinical practice rooted in anti-oppressive, anti-racist, culturally safe and linguistically appropriate care.

    - CHCs endorse the Alliance for Healthier Communities' Health Equity Charter and monitors its progress against health equity indicators (such as via the Health Equity Charter Self-Assessment Tool)
- Our model of care is centred on reducing barriers
    - Our neighbourhood approach means anyone in the geographic catchment has access to programs and services (including interprofessional team members), regardless of if they are a primary care client or not.
    - Our model of care is grounded in the Model of Health and Wellbeing, which focuses on health equity and the social determinants of health; community and person centred-ness, population needs, interprofessional care and accountability.
- This funding will also enable further targeted outreach efforts leveraging Community Ambassadors to reach unattached residents, and support language interpretation services and navigation for clients
- Our team will continue to grow our collaborations beyond the health system, with community organizations and social service providers to address the social determinants of health and provide comprehensive support to disadvantaged populations.
- FHC-CHC is the highest-performing *high-priority communities* fundholder in Ontario and has a dedicated commitment to performance management, including the collection of patient-reported experience and outcomes (PREMs and PROMs)

Additional considerations:

- *Socioeconomic status*
    - Over 60% of FHC-CHC clients are in the lowest-income quartile, with only 13% in the highest two quartiles.
- *Racialized Populations*
    - FHC-CHC has a long history of working with the local racialized communities and has representatives from these communities to support the co-design and delivery of programs and services.
    - A few examples include:
        - Long-standing collaborations with the Chinese community. FHC-CHC Fairview has Mandarin and Cantonese-speaking peer leaders from the local community.
        - FHC-CHC is working in partnership with COSTI since they have refugee hotels in the local community in order to provide primary care for the residents of these hotels.
- *Francophone Population*
    - While this is not an area of high need for French Language Services, culturally safe and linguistically appropriate care priorities in the recruitment of all FHC-CHC team members, including the expanded team. French Language Health Services (FLHS) considerations will be fully considered and FHC will work with Entité 3 and other local FLHS

service providers (ex. Centre Francophone du Grand Toronto, TAIBU) as needed.

- *Indigenous Populations*
  - All new providers will be trained in Indigenous Cultural Safety and made aware of how to connect Indigenous clients to culturally appropriate services. Although less than 1% of the population in the area identifies as First Nations, Métis and Inuit (FNMI)**,** FHC-CHC works closely with Indigenous partners such as Anishnawbe Health to ensure Indigenous Health is in Indigenous Hands.

3. Increase Access to Primary Care:

- To increase access to primary care, the expanded interprofessional team identify and remove all barriers to access experienced by different populations. This includes offering additional hours and days of operation, including evening and weekend clinics to accommodate the needs of working individuals and families. Same-day access, home visits, and virtual care services are available across all providers (primary care and interprofessional providers) to improve accessibility and convenience. The team will also utilize interpretation services in order to increase access to primary care for non-English speakers and has 24/7 on-call services provided by practice physicians and medical residents.

4. Efficient and Effective Governance

- The North York FHT and the CHCs and community partners for this submission all have well-developed governance models and Boards who are fully supportive and prepared to provide oversight to ensure the deliverables of the team-based expansion are met. Moreover, the NYFHT and other EOI partners are Core members of the NYTHP and part of our OHT's Governance table – the Stewardship Council – ensuring that this initiative will be regularly monitored by the NYTHP. This model will have accountability to the collective members of the OHT for advancing shared goals related to improving access to comprehensive primary care and health equity for the populations served.

5. Team-Based Models of Care

- The expanded interprofessional team will practice within a comprehensive primary health care model that is rooted in the Model of Health and Wellbeing. This involves offering primary care services in combination with health promotion, prevention, and community development activities to address the social determinants of health and providing care from an anti-oppressive, anti-racist and health equity lens. This includes not only addressing medical and biological issues, but also improving the circumstances in which people live, work, play and age. Comprehensive primary health care not only improves the health of individuals, it also creates healthier communities.

6. **Integration with other providers.**

- The model includes linkages with the 21 Core and approximately 30 Alliance members of the NYTHP who represent the continuum of health care as well as social care and culture-based services for the populations and neighbourhoods supported by this model.

7. **Team-based models of care that maximize scope and how the team works together.**
    - This model builds on the established approach of the lead agency, the North York Family Health Team, of maximizing the full scope of practice for all members on the interdisciplinary team. The other primary care partners that are part of the NYTHP are equally committed to and have demonstrated experience creating and sustaining high-functioning interdisciplinary teams that enable all disciplines at practice to their full scope. The model will involve at over 10 regulated health professionals in different teams designed for the populations served. The Department of Family and Community Medicine (DFCM) at North York General Hospital, Canada's largest community-based teaching site, is a key partner. Therefore, all trainees in our community learn how to work in an interprofessional model.

8. **Integration and collaboration with primary care partners and Ontario Health Teams and participation in population-based planning and service delivery**.
    - The goal of this proposal is to bring team-based care services to all individuals in our region, across all primary care models. This includes working with existing providers and establishing new primary care providers in our region and delivering care through multiple modalities including co-location, mobile teams and virtual care in response to the needs of the population and partnerships. The University of Toronto's DFCM at North York General Hospital will support the learning and training of new practitioners, skilled at practicing in a team-based model.

9. **A commitment to a learning health system philosophy (using data and evaluation for continuous quality improvement).**
    - The expanded IPC team will adhere to learning health systems principles by generating data as implementation occurs and translating data into knowledge for monitoring and Quality Improvement. An evaluation plan will be developed per program and align with (c)QIP goals where possible. During regular team meetings, there will be a regular review data/metrics to monitor progress towards QIP goals. This will include a review of qualitative insights and feedback from members of the NYTHP's Patient and Caregiver Health Council and/or Patient and Family Councils of the FHT/CHCs that are part of the expanded IPC team
    - North York FHT family physicians are already encouraged to sign up for their Screening Advisory Report (SAR) and to review them regularly. The team will also use existing initiatives with indicator targets reflecting our collective priorities (e.g., cancer screening).

- The NYFHT is also a significant teaching and training site for family medicine residents. The strong partnership between the NYTHP Primary Care Network and University of Toronto's Department of Family and Community Medicine enables health system learning to be continuously fed back to the Department and vice versa.

10. **Improve patient engagement** (including diversity that represents the community served) and patient-centred care.
    - The expanded primary care team will be supported by a robust community engagement framework (using the International Association for Public Participation methodology) and resources from the NYTHP, including our OHT's diverse Patient and Caregiver Health Council, the NYTHP's multi-partner Communications and Community Engagement Committee and an ongoing partnership with Ambassadors and neighbourhood and population-specific networks across North York. Health Equity Impact Assessment (HEIA) and other tools and frameworks from the CHCs and other partners will be used to guide patient and community engagement approaches to ensure inclusion of diverse and equity deserving communities in program and service design, delivery, and evaluation.

11. **Use digital health solutions to support care delivery.**
    - A full range of digital and virtual care tools, already adopted and developed by NYGH and NYTHP, will be leveraged to support team-based primary care delivery and to enhance the experience of patients and providers. This includes Seamless Care Optimizing Patient Experience (SCOPE); Online Appointment Booking (OAB); eReferral; Evidence 2 Practice (E2P); MyChart; Health Information Exchange (HIE); Remote Patient Monitoring (RPM); and a Patient Navigator.

12. **Support the principle of providing the right care in the right place.**
    - Supported by a single EMR, the enhanced primary care team and practices involved will connect with home and community care, LTC, North York General Hospital, mental health care and a range of community and social care providers to ensure that patients are assessed and connected to the right care in the right place, according to their needs. Common assessment tools and shared care plans, created with patients/clients/families/caregivers, will help ensure that individuals receive the most appropriate care in the most appropriate settings according to their needs, and reflecting their circumstances, values and preferences.

13. **Be agile and responsive to the needs of the community over time and in crisis responses (including providing guidance or referrals to social service supports).**
    - Through the dynamic and continuous collective review of data – local population level, patient-level, performance data (c)QIP and other indicators, and qualitative feedback/insights from patients, caregivers and diverse/equity-deserving populations, the expanded IPC team and its partners will stay current on population and community needs over time. The broad and closely

connected NYTHP partners continuously monitor, anticipate and organize to respond to emerging issues and crises in the community (this was demonstrated throughout the local COVID response).

This happens at various levels of the NYTHP including the Stewardship Council, which monitors community risks and issues and conducts ongoing roundtables on system-level challenges and pressures. Initiatives such as the Mental Health and Addictions Service Resolution Table of the NYTHP can be replicated as a collaborative multi-partner approach to rapidly identify and respond to client crises in the community.

By design, the expanded IPC model includes connections with community and social services organizations serving North York and processes for referrals, warm transitions and integrated service delivery to address the social determinants of health.

SECTION 3: ABOUT THE CLIENTS AND PROGRAMS

This section provides information about the services the IPC team proposes to deliver to meet the community's health care needs.

NOTE:
To help you fill this section, please refer to the Health Equity Impact Assessment (HEIA) Tool. The HEIA Tool helps users to advance quality and equity in health care service design and delivery. By using this tool, users will be able to identify priority populations, mitigation strategies (e.g., proposed programs, improved process) and potential community collaborations.

3.1 Priority Populations Served

Please briefly describe the priority population(s) the IPC team plans to serve, including a target for the number of people without a primary care provider that will receive primary care services (e.g., unattached patients, uninsured patients, patients with chronic diseases, HIV+ patients, mental health or addictions issues, elderly, newcomers and refugees, young families, socioeconomically disadvantaged groups, Indigenous people and communities, Black, other racialized or Francophone communities, and people in supportive care/long-term care, etc.).

The uncertainly attached number in our region is 43,841 individuals. And about 400,000 are currently not connected to a team-based primary care service model (CHC or FHT). This EOI aims to attach 12,000 individuals and provide access to team-based care services to all individuals in our region.

Each neighbourhood in NYTHP is diverse and requires a specific focus based on their needs and current make-up. Through our analysis of the data and engagement efforts we have identified the following specific targeted areas for each neighbourhood. This does not mean other issues do not exist in these neighbourhoods, but that as teams expand in these areas there will be an initial focus on target the conditions and modes of care delivery. Priority populations will vary from neighbourhood to neighbourhood.

The table below summarizes the focus areas for each of our 18 neighbourhoods.

Neighbourhood	Language (Where mother tongue for population is not English for >50% of population)	Seniors	Comprehensive Primary Care (lower attachment)	Diabetes	CHF	Mental Health	Complex Conditions (4 or more)
Banbury-Don Mills		x			x	x	x
Bathurst Manor	x	x	x		x	x	x
Bayview Village	x	x					
Bayview Woods-Steeles	x	x		x	x	x	x
Clanton Park			x		x	x	
Don Valley Village	x	x	x				
Henry Farm	x		x				
Hillcrest Village	x	x		x	x		x
Lansing-Westgate	x		x				
Newtonbrook East	x	x					x
Newtonbrook West	x	x	x		x	x	
Parkwoods-Donalda	x		x	x	x	x	
Pleasant View	x	x		x	x	x	
St. Andrew-Windfields	x	x	x				
Victoria Village	x	x	x	x	x	x	x
Westminster Branson	x	x	x	x	x	x	x
Willowdale East	x		x				
Willowdale West	x	x			x	x	x

Using the Health Equity Impact Assessment (HEIA) tool, the potential impacts, mitigation, and monitoring were reviewed for the populations we will be serving. We identify that there may be some small populations that are widely represented in a select neighbourhood that we may miss in our initial planning. Through creating neighbourhood-based team-based services, we would learn more about the individuals in these populations as they started accessing our services (a positive impact) and may learn that that our approach to care is not culturally appropriate (negative impact).

We will gain more information about the individuals through direction interaction with them, assigning our Ambassadors to do outreach to specific groups, or through whichever channels are most appropriate. We will then look for ways to mitigate the impacts (collaborating with the populations and Ambassadors as needed) and effectively design team-based care according to the populations' self-defined needs. Since our organizations have been doing this work for some time, we have already had demonstrated success in mitigating impacts on equity-deserving populations already. For instance, in some of the ethno-racial communities in our eastern neighbourhoods, our organizations have ensured we offer care and health resources in languages that reflect the population in these neighbourhoods, we have providers that reflect the population, the care is designed to respond to cultural values and sensitivities, and we continue to have ongoing community outreach through our patient advisory groups and community Ambassadors, to support health services and programs.

3.2 Proposed Programs and Services

Please complete the following table (adding additional rows as needed), indicating the services the IPC team will provide directly or in coordination with others. Please also indicate whether the programs will be accessible to all residents in the community.

Please describe, for each program and/or service offering outlined, how it will be enabled by communication/shared care planning across the IPC team.

Program Name	Staff Involvement (Type and FTE)	Program Description	Goal	Target Population	Target # of Patients (per year)
Seniors Wellness	3 NP 3 SW 2 OT 2 PT 2 RN 1 RD 1 Pharmacist 3 Chiropodist	Patients who have been identified by their primary care provider as homebound, complex/multiple conditions, who require care, treatment and collaboration with other community partners to support wellness and health in particular those who are marginalized	To support seniors to live at home with the knowledge and confidence to stay well and healthy and out of institutional care (e.g., hospitals, LTC, etc.) using a culturally appropriate approach	Seniors with complex conditions	1500
Nutrition	10 RD	Guiding and empowering patients toward healthier living through nutritional health services and group programs based on interdisciplinary collaboration, evidence-based knowledge, based on individual circumstances, and culturally appropriate and adaptive to living in North York. This program will also support those with or at risk for diabetes	Patients gain the knowledge/skills/tools to confidently make healthier eating choices	Adults requiring counselling and support regarding nutritional issues related to their health and illness	5000
Prevention & Wellness	82 RN 10 RPN 5 Case Worker 5 Midwives 5 Community Ambassadors 2 SW 2 RD 1 PT 1 OT 3 Pharmacist	Support patients with their primary care needs including but not limited to immunizations (babies, children and adults), diabetes checks and management, prenatal and well-baby visits, cognitive assessment, cancer screening, wound care, social prescribing, hospital follow-up, falls assessment, referrals to home and community care programs, and navigation to community	Improve cancer screening rates, reduce HbA1c levels, reduce less urgent ED usage, lower falls rates	Entire population at risk for any of the conditions being assessed	100,000

		supports. This care will be provided in clinics, but will also include outreach to communities to promote health and bring people into our clinics to receive care, and potentially attach them to primary care			
Mental Health and Wellness	28 SW 2 Psychologist 2 Case Worker	Providing individuals with psychosocial support for various chronic and acute mental health conditions (e.g., depression, anxiety). This program would provide assessment, treatment and evaluation of individuals and families related to interpersonal problems, ineffective patterns of behaviour, and psychosocial issues, through individual counselling or facilitated group sessions.	Provide individuals with quality care and timely access to short-term psychosocial counselling; Provide education and support to patients to enhance coping and insight; Connect patients with resources as needed; Individuals see an improvement in their GAD-7, PHQ-9 scores following completion of the program	Individuals with mild to moderate mental health conditions	4000
Primary Care for Patients with Complex Conditions (Physical, Mental Health, Palliative, Cancer, Homebound)	8 NP 3 SW 1 OT 1 PT 8 RN 2 RD 2 Pharmacist 1 Chiropodist 3 Care Coordinators	Nurse Practitioners with additional training and education in the area of care identified who lead the provision of primary care services and partner with interprofessional team members based on patient needs. The program builds on the success of existing programs such as NYFHT's Homebound Program, CMHA's ACT Teams, Leong Supportive Geriatric Outreach Program, NYFHT's Colorectal	Provide attachment to primary care services for patients with complex conditions.	Unattached, complex patients	5000

		Cancer Survivorship and many more. The goal is to expand these successful programs to more people in our region.			

3.3 Integration and collaboration with OHT and local primary care sector

In 2019, OHTs were introduced to better connect a fragmented health system. Since then, 54 OHTs have been approved and are creating successes, including more efficient hospital-to-home transitions, strengthened primary care foundations locally, improved digital health and virtual care access, better data and analytics, and more meaningful partnership and engagement with patients, families, and caregivers.

Please describe how the proposed IPC team will work within the OHT to improve the integration and coordination of care for the attributed population. For Indigenous Primary Health Care Organizations presently not connected to one OHT, please provide additional details regarding how you intend to work to build partnerships across the continuum of care.

Please describe how the proposed IPC team will leverage and expand the use of digital health solutions in alignment with the provincial digital health strategy and digital health priorities for OHTs.

Our IPC team is synonymous with our OHT – it is one and the same.

NYTHP is committed to a Compassionate North York, underpinned by a foundation of Compassionate, team-based primary care for all who live in or receive care in North York.

As such, our IPC team will encompass our NYTHP primary care network, our 22 OHT Core partners, as well as our Alliance Partners and other community partners and leaders. This proposal also includes our 5 existing team-based models in North York, North York Family Health Team (NYFHT), Flemingdon Community Health Centre, Fairview Site, Unison Community Health Centre, Bathurst-Finch Hub, Vibrant Healthcare Alliance and the Baycrest Inter-professional Primary Care Team. Plus, the Department of Family and Community Medicine at North York General Hospital, at the University of Toronto. This is a full OHT team approach.

This will enable us to truly provide access to team-based primary care to everyone in North York, with a priority on equity-deserving populations who are currently unattached to primary care.

This proposal is grounded in the principles of equity and inclusion. Everyone is in.

Our approach began with a focus on how we close the gaps within our communities, with a key priority being enabling primary care access to unattached patients in North

York. Through accessible quantitative and qualitative data (i.e., community engagement and local partner lived experience and expertise) we know that those of lower socio-economic status, newcomers, people with disabilities and people with insecure housing are more likely to be unattached and are the first priority for our work. Available data and experience point us toward certain priority neighbourhoods within our communities, and certain populations within those neighbourhoods. For example, 16-29% of the population in 8 of our North York neighbourhoods are considered low-income residents (vs. Toronto's 13.2%), a higher concentration than most other Toronto OHTs. In one such neighbourhood, the material deprivation score is in the lowest quintile due to the affluent surrounding areas, but the densely populated strip of apartment buildings along the main street houses a high concentration of lower-income and vulnerable residents and seniors. We will leverage our existing partnerships with community organizations, and members and leaders both within and beyond our OHT to help identify, co-design and continuously improve team-based primary care to first unattached and then eventually all patients in North York.

If successful, all primary care providers will become members of our Primary Care Network and be able to access team-based care. Our Primary Care Network (230+ physicians have joined to date) will be leveraged as part of this proposal, and recruitment of new members is ongoing, with an aim of reaching every primary care provider in North York (physicians, nurse practitioners, midwives and other clinicians). As the foundation for our OHT, the Primary Care Network is committed to NYTHP's Shared *Purpose Compassionate North York*, which is founded on improving equity for our community. A core tenet is that our primary care providers will collectively care for our most vulnerable, unattached patients in North York.

Our ever-growing Primary Care Network and OHT partnership have already been leveraged to implement innovative, integrated pathways for our patients – such as enabling cancer screening for unattached and equity-deserving individuals in North York. One key avenue has been through our Community Health and Information Fairs (CHIFs), which are barrier-free, convenient, culturally safe clinics that offer clinical and social determinants supports to our community, including vaccinations, colorectal, breast and cervical cancer screenings (on-site! and on demand!). We have offered these Fairs in neighbourhoods that have been identified as having specific equity-deserving communities who have experienced barriers to care (e.g., linguistic communities, ethno-racial communities, food-insecure). To date, we have held 13 CHIFs and outreached through our community health ambassadors, bringing equity-deserving community members essential information about cancer screening and preventive care, and most importantly, engaging them in a trusted relationship which enables them to feel comfortable accessing primary care (in some cases for the first time). Unattached individuals with intersecting needs are often connected with care through CHIFs, sometimes becoming clients of CHCs, receiving cervical cancer screening through the Fair's primary care provider, or being connected to social services. This could not have been accomplished without the fundamental partnerships with our Primary Care Network, providers (CHCs, NYFHT), as well as our many community OHT partners (social services, legal, food security, etc.). In addition, our embedded evaluation scientist within the NYTHP has conducted and

built capacity for continuous improvement into our community outreach, bringing a learning health system lens to this work. These foundations and relationships with our community will be at the heart of how our IPC will improve coordination and continuity of care for our community.

The implementation of our expanded team will allow us to continue building partnerships with all health service providers in our OHT. For instance, partnering with CMHA to deliver our Mental Health supports and NP-led program will ensure we are leveraging strengths from all organizations and implementing a community-based approach. Partnering with our home care providers directly to coordinate and support our programs for homebound patients or others who would benefit from a home visit allows us to coordinate all services – home care or primary care, or other – required by the patient and their family/caregiver and to provide the experience of having one team wrapped around them.

Our solutions are OHT-level focused and guided by the trusted relationships we have developed over the years to determine how do we best care for our communities.

3.4 Digital Health Solutions and Provision of Care

Please describe how your existing or new team will incorporate digital health solutions into the provision of care and provide digital health and virtual care options to your community.

Electronic Medical Record

Each of our current practices utilizes an electronic medical record (EMR). The expanded teams will leverage the existing tools and practices which also support regional tools and processes. This will ensure the smoothest transition and leverage existing resources.

Teams will continue to leverage existing provincial tools such as ConnectingGTA, OLIS, Hospital Report Manager, etc. as these are connected to current practices.

Today, our practices are focused on providing care in-person and virtually. We use patient and provider assessments to determine the best mode of care delivery for our patient populations. The vast majority of attached patients have access to virtual care services through their primary care providers. There is currently a natural increase in demand for more in-person care, which our practices have moved toward. Where appropriate, and according to standards established by Healthcare Excellence Canada and Ontario Health, virtual care is offered and delivered either using telephone, EMR-embedded tools, or Zoom for Healthcare. For our unattached patients, we will continue to offer our practices along this same manner.

NYTHP has focused heavily on developing digital health and virtual care tools over the past three years at an OHT level. These are used today by members of the

existing team-based care providers and would be further leveraged and expanded for use by the IPC to enable an integrated patient and provider experience.

An overview digital health solutions:

Seamless Care Optimizing Patient Experience (SCOPE):
SCOPE is a single point of access (phone number) for primary care providers to reach an interprofessional team. Ocean eReferral is also another way that primary care providers can refer into the SCOPE program. This program better connects primary care providers with resources, such as services within the hospital. Through SCOPE, primary care providers can access medical imaging, General Internal Medicine, pediatricians, general surgeons, palliative care, and more, creating an integrated care experience for patients.

Online Appointment Booking (OAB):
The NYTHP Online Appointment Booking program aims to increase patient access to care by streamlining the appointment booking process. Primary care providers and team-based care providers have implemented online appointment booking in many instances today. This practice would continue with the expanded team. Online appointment booking removes the common problem of patients having difficulty getting through to their primary care providers' offices. It also reduces the number of inbound phone calls, freeing up office administrators' time to do other important direct and indirect patient care activities such as registering patients who arrive for visits, troubleshooting virtual care, following up on specialist or imaging bookings, updating patient records, and more. Primary care providers, clinic staff, and, most importantly, patients all gain from online appointment booking as it allows more time to be spent on patient care.

eReferral:
Ocean eReferral allows healthcare providers to securely send electronic referrals in real-time while keeping patients informed. Patients also receive real-time electronic updates on the status of their referral and no longer need to wonder if their provider sent the referral or if the "fax" was delivered properly to the receiving clinic. We have engaged primary care clinicians across our network to use eReferral and pass on these important benefits to the patients they serve. NYGH is actively onboarding its hospital-based clinics as receiving providers for the same reason. NYGH will continue to implement eReferral across several prioritized departments such as medical imaging, specialized geriatrics, diabetes educations and breast centre. As a team, we continue to engage our providers and OceanMD to improve the user experience and promote further uptake of this vital digital health tool. Team-based providers have started exploring the use of e-Referral to transfer medical information and enable seamless referrals between providers on different EMRs.

Evidence 2 Practice (E2P):
Partners of NYTHP are working closely with provincial partners (Centre for Effective Practice, eHealth Centre for Excellence, Ontario Health) to implement digital tools and health information system enhancements through the E2P program. These tools and digital enhancements are implemented in primary care provider offices and hospital

information systems respectively, with the goal of supporting evidence-based care, according to the quality standards across the patient's care journey. One example of health information system enhancements is working with acute care hospitals to improve their discharge summaries to primary care providers, and patient family advisors, according to the PODS (patient-oriented discharge summary) principles. These enhanced patient discharge summaries aim to facilitate more seamless care transition from hospital to home, providing both patients and providers with the necessary information (e.g., medication reconciliation, follow up appointments, etc.). Similarly, primary care providers are leveraging these tools to support change management that aid primary care clinicians to deliver quality care. Tools are available in Telus PSS for heart failure, and in OSCAR and Accuro for anxiety and major depression. Clinicians, people with lived experience, digital health experts and OHTs across the sector are engaged in the development and deployment of these enhancements/tools to ensure widespread adoption.

MyChart:

MyChart is a secure website and mobile application which allows the patient to access their medical information completed at NYGH anywhere, anytime. For 2023-24 we will continue to inform our patients about this tool. We also aim to provide our clinicians with supporting materials on how to set expectations with patients around real-time access of MyChart results and bring in leaders from other organizations to talk about their experiences with real-time access for patients.

Health Information Exchange (HIE):

HIE is a technology platform that connects disparate systems together to share key clinically relevant patient information. It reconciles provider health records into a single consolidated shared record. As HIEs are vendor agnostic, they do not replace EMRs, but rather offer a flexible, interoperable platform on which to pull the right information, at the right time to the right place. NYGH first use case for 2023-24 will be implementing integration with PointClickCare. We will link data across our acute care hospital and long-term care homes and plan to expand to other partners to enable more seamless data-sharing amongst our partners, especially those in Primary Care.

Remote Patient Monitoring (RPM):

NYGH will continue to offer and expand remote patient monitoring using several digital technologies to collect patient data. Remote monitoring allows health data from individuals to be collected in one location and electronically transmitted securely to health care providers in a different location for assessment and recommendations. Currently NYGH is completing remote patient monitoring with our surgery patients and our NYGH@home patients.

Patient Navigator:

NYTHP currently has a patient navigator that facilitates patient access to many NYGH tools and resources. The patient navigator will be enhanced in 2023-2024, with the addition of resources from the Toronto region. It will ultimately include information from all OHT's within Toronto.

SECTION 4: IMPLEMENTATION

This section provides information about the implementation plan, associated risks, and how you plan to manage and control these risks to ensure successful implementation.

4.1 Implementation Plan

Please provide a plan detailing how you intend to implement and deliver the proposed program and service(s). The implementation plan shall include, but not be limited to, all activities required to be completed and by whom, and a detailed implementation schedule including all milestones.

With the experience and expertise of strong team-based care providers in our region, we are ready to expand! We know how to do this work and are awaiting the resources to provide our level of team-based care to more people in our region.

Step 1: Months 1 to 3 – Initiating

Upon approval of funding, OHT partners will convene to confirm the sequencing of neighbourhoods to implement team-based care.

Neighbourhood-level implementation teams will be created, led by one of the team-based care providers in the OHT. This provider will be designated the lead for this neighbourhood. The implementation team will include patient advisors, physicians and providers in the region. There will be one dedicated implementation team for each neighbourhood as there will be many initiated at the same time. All teams will report into the NYTHP's Primary Care Council.

Implementation team will connect with existing primary care providers in the region, including physicians who are not affiliated with FHT or CHC and are brought into the planning circle to review and confirm programs and services identified for the neighbourhoods.

Lead team-based primary care organization will recruit identified interprofessional team members and onboard them to their host organization

*Note on recruitment: while this is a difficult environment for recruitment, NYFHT has been very successful in our recruitment efforts over the last several years. Our turnover rates have been extremely low, with most vacancies as a result of individuals taking parental or medical leaves rather than leaving for new opportunities. Where we have needed to recruit, successful candidates have been brought in within 1-3 months, especially when roles are posted as permanent positions. While we are aware of the current environment's challenges, we are positive our approach, work culture, and work in the community sector, are known and will result in us being able to achieve the stated timelines.

In parallel, we will set up referral mechanisms with primary care providers and engage IT support in the physicians'/providers' offices to ensure seamless connections to

team-based services. We will involve eHealth Centre for Excellence, OntarioMD and Ocean as required.

Step 2: Months 3 to 9 – Commencing Care Provision

Onboarding will continue through shadowing of existing team providers and cross-collaborating with other providers in the region so care professionals are fully aware of the services available in the neighbourhood and community at large and start to build camaraderie with their other team members.

With interprofessional team hired and oriented, host organization will begin provision of care services and patients will be referred by primary care providers selected

Through neighbourhood team and supported by the OHT, promotion and outreach to community will be underway, including hosting Community Health Information Fairs in target neighbourhoods. This will also provide a mechanism to receive feedback and continue to partner with diverse communities to understand needs, barriers and the most effective approaches to care delivery. Other providers in the OHT will be part of our CHIFs further extending the services offered to equity-deserving groups.

Step 3: Months 9 to 12 - Evaluation

Led by PCN and the neighbourhood implementation team, we will evaluate implementation by reviewing referrals and service uptake. Evaluation is an embedded function in NYTHP's efforts. Adjustments will be made to processes and programs if required based on community and provider feedback

During this time, we will prepare for second year of operations.

4.2 Capital Needs

Has a location(s) been identified to provide the proposed IPC team services? In the box below, please provide the exact address(es) if your location has been identified. Please also describe the scope of any renovations or construction the location(s) will require before being fully operational, and the approximate length of time it will take for your

proposed site to be “move-in ready” following approval. Please be sure to identify or reference the contributions towards capital or infrastructure (if any).

The existing sites of our team-based care providers in North York will act as the central sites for expansions.

- 240 Duncan Mill Road
- 5 Fairview Mall Drive
- 2398 Yonge Street
- 540 Finch Avenue West
- 12 Flemington Road
- 3560 Bathurst Street

Plus, some other primary care provider physician offices will accommodate team members, such as nurses, counsellors, and care coordinators to enable patients to access care in places that are familiar and comfortable to them.

To get started, sites will accommodate the expanded team members into existing spaces.

Many of the sites also have additional spaces (units, rooms, etc.) that they can grow into, as needed. Leasehold improvements in these expanded spaces may be required and would be worked out with landlords as needed.

4.3 Risks and Mitigations

Please identify and describe any risks, contingencies, and circumstances, which are inherent in, or which you may encounter in the development and implementation of the proposed services, as well as the applicable mitigation strategies for all risks, contingencies, and circumstances.

Physician uptake of digital solutions

- We may need to direct resources to support engagement and implementation in the short-term to get primary care physicians set up with eReferral and EMR standards. Many physicians in the community, especially those serving equity-deserving patients, have limited time and resources to manage change processes.

Community Consultation

Ensuring we are able to effectively engage our communities during the implementation phase may result in timeline delays. We may choose to move ahead in program areas we know will be successful first as we finetune the implementation of programs targeting new communities/ have specific cultural considerations. However, taking the time up front to work with the communities affected will be beneficial in the long run.

Human Resources

- Even with recent successful recruitments, there may be delays due to the availability of health professionals. This may require us to staff up in areas where we can and modify the timing of other programs and activities.

4.4 Health System Learning and Quality Improvement

Please briefly describe how the IPC team will adhere to learning health principles (e.g., how evidence will be systematically gathered and applied to guide care, how patients will be included as learning team members and a description of the planned feedback cycle for improvement and learning).

Please identify and/or describe the plan to ensure and improve the quality of care and services. If there is no Quality Improvement Plan (QIP) in place, please describe how you would collaborate with the ministry to develop and implement a QIP (Guidance for developing a QIP can be found here).

It is recommended that MDs sign up for their Ontario Health Screening Activity Report, myPractice Report, or equivalent.

The most recent information about provincial QIPs can be found here: https://www.hqontario.ca/Portals/0/documents/qi/qip/annual-memo-2023-2024-en.pdf

The expanded IPC team will continue to adhere to learning health systems principles by generating data as implementation occurs, making collective sense of the data so that it becomes knowledge that is applied, and monitoring performance with feedback mechanisms for ongoing quality improvement. An evaluation plan will be developed per program and align with Collaborative Quality Improvement Plan (c)QIP goals where possible. During regular team meetings, discussions will take place to review data/metrics for programs and to monitor progress towards QIP goals. Members of the Patient and Caregiver Health Council and/or Patient and Family Council will be part of the expanded IPC team, as they are for all NYTHP initiatives, and share insights and feedback during team meetings.

NYTHP's (c)QIP is focused on improving cancer screening rates, ALC and mental health. The expanded IPC team will help implement the change ideas in our (c)QIP and either help us to achieve our goals faster or exceed our targets without investing added resources. See Appendix K for our (c)QIP

Our physicians are already encouraged to sign up for their SAR and to review them regularly. We have existing initiatives that remind MDs of the monthly SAR and have set indicator targets reflecting our collective priorities (e.g., cancer screening). As outlined in our(c)QIP, we are aiming to increase the percentage of screen-eligible people who had a Pap test within the previous 3 years; following data analytic work, we are focusing on patients seen by physicians who have been identified as "low-screeners." The

expanded IPC team will also be participating in our cancer screening initiatives offered at local CHIFs, which offer low-barrier access to pap testing from female primary care providers. The expanded IPC team would provide the necessary clinical staffing to continue offering on-site pap testing, particularly for unattached patients and uninsured individuals. The Patient and Caregiver Health Council strongly supports the CHIFs and this model has created enduring partnerships between NYTHP partners and various other community and social care agencies, supported by Community Health Ambassadors/local neighbourhood advisors.

NYFHT along with partners such as NYGH are teaching and training sites for family medicine residents, nurses, social workers, and various other practitioners. NYTHP and the Primary Care Network have strong partnerships with the University of Toronto's DFCM enabling continuous health system learning.

Checklist for IPC Team Expansion EOI Template

☐	Completed Document #1 – *IPC Team Expansion EOI Template* Application(s) to be sent in PDF or Word format
☐	Supporting or additional documentation in clearly defined appendices
☐	Scan and attach all commitment letters as identified in the application
☐	Proposed Budget

Expression of Interest - Interprofessional Primary Care Teams
Proposed Budget
North York Family Health Team - North York Toronto Health Partners EOI
Family Health Team / OHT Model

HUMAN RESOURCES	Full-Time Equivalent (FTE)	Base Funding
Management and Administrative Personnel	38.00	$ 2,673,609
Interprofessional Health Providers	204.00	$ 15,746,809
Total Salaries		$ 18,420,418
Total Benefits		$ 4,144,594
TOTAL Human Resources		**$ 22,565,012**
SALARIED PHYSICIAN COMPENSATION		
Salaried Physicians (for CHCs)	1.50	$ 427,853
Total Physician Compensation		**$ 427,853**
OPERATIONAL OVERHEAD		
General Overhead (25%)		$ 5,748,216
Total Operational Overhead *		**$ 5,748,216**
Total Proposed Base Funding		**$ 28,741,081**
ONE-TIME FUNDING		
One-Time Funding Furnishings and Equipment		$ 100,000
One-Time Funding IT		$ 834,000
One-Time Funding: Minor Renovations		$ 250,000
Total Proposed One-Time Funding		**$ 1,184,000**
Total PROPOSED Base and One-Time Funding		**$ 29,925,081**

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – Commitment to NYTHP's response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing this letter on behalf of Flemingdon Health Centre to express our commitment to partnering with North York Toronto Health Partners Ontario Health Team (NYTHP-OHT) for the submission of the proposal "*Compassionate team-based primary care for all*" to expand primary care services to unattached equity-deserving populations in the North York area. We firmly believe in our position to serve the unattached complex population with the care that they deserve and need. This letter serves as our formal commitment to collaborating and contributing to the expansion of primary care services.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of the fastest-growing neighbourhoods. We are committed to working collaboratively as one team to increase access to care for all and prioritizing the unattached, equity-deserving populations in our North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

Flemingdon Health Centre (FHC-CHC) supports this proposal alongside our fellow anchor agencies of the NYTHP OHT Primary Care Advisory Council and the NYTHP OHT at large. As one of the lead organizations supporting team-based care expansion, we at FHC-CHC are committed to supporting and providing comprehensive primary care rooted in health equity for the population of North York.

Leveraging our 48 years of experience in serving the region's equity-deserving populations, we will be able to support the attachment of clients to primary care and provide services to all local residents through our neighbourhood model of care. As one of the highest-performing interprofessional teams in the province and highest-performing *high-priority communities* fund-holder, we are proud of supporting the government's quintuple aim while providing anti-oppressive, anti-racist, culturally safe, and linguistically appropriate care.

We are proud to support compassionate, comprehensive interprofessional primary care for all as the foundation for advancing population health in our community and beyond.

If you have any further questions or require additional information, please do not hesitate to reach out to us.

Sincerely,

Jennifer Quinlan, CEO
Flemingdon Health Centre

cc: North York Toronto Health Partners C/O Ivy Wong

North York Toronto Health Partners C/O Ivy Wong
4001 Leslie St.,
Toronto, Ontario, M2K 1E1

June 9, 2023

Subject: Letter of Commitment for Partnership to Expand Primary Care Services

Dear Ivy,

I am writing this letter on behalf of Vibrant Healthcare Alliance to express our commitment to partnering with North York Toronto Health Partners in expanding primary care services to unattached equity deserving populations in the North York area. We firmly believe in our position to serve the unattached complex population with the care that they deserve and need. This letter serves as our formal commitment to collaborating and contributing to the expansion of primary care services.

Vibrant is dedicated to promoting equitable access to healthcare and improving health outcomes for underserved communities. We recognize the pressing need to expand primary care services to equity deserving populations, as these communities often face significant barriers to accessing comprehensive and timely healthcare. We fully support your mission to bridge this gap through Ontario Health's expression of interest in expanding primary and allied health services in the North York area.

As part of our commitment, Vibrant pledges to bring our resources, expertise, and collaborative spirit to this partnership. If successful in obtaining adequate financial resources from Ontario Health, Vibrant is prepared to contribute:

1. Human Health Resources: We will provide relevant resources, such as nurse practitioners, chiropodists, physicians, other allied health professionals, administrative and project support. This will include sharing our knowledge of community needs, healthcare trends, and successful models of care.
2. Collaboration and Program Development: We are eager to work closely with North York Toronto Health Partners to develop joint programs and initiatives that address the unique needs of unattached equity deserving populations. We will actively participate in the design, implementation, and evaluation of these programs, ensuring they align with the goals of our partnership.
3. Advocacy and Outreach: Vibrant will advocate for the expansion of primary care services to unattached equity deserving populations within the broader healthcare community. We will engage stakeholders and partner organizations to ensure that we're always providing the care to the right people at the right time in the right places.

We firmly believe that our collective efforts will create lasting impacts and improve health outcomes for the individuals and families in the North York area. By pooling our resources and expertise, I am confident in our ability to develop innovative solutions, increase access to care, and ultimately reduce health disparities among equity deserving populations.

If you have any further questions or require additional information, please do not hesitate to reach out to us.

Sincerely,

Ben Vozzolo, MSc, MBA | Chief Executive Officer

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – NYTHP's response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing to confirm our commitment to the North York Toronto Health Partners Ontario Health Team's (OHT) proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods. We are committed to working collaboratively as one team to increase access to care for all, and prioritizing the unattached, equity-deserving populations in our North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support of our entire OHT and Primary Care Advisory Council – anchored by our four existing primary care team-based models in North York: the North York Family Health Team, Flemingdon Community Health Centre, Unison Community Health Centre and Vibrant Healthcare Alliance.

As one of the lead organizations supporting team-based care expansion, we at Unison are committed to support team-based care for the population of North York.

We am proud to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Michelle Joseph
CEO, Unison Health and Community Services

June 16, 2023

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – North York Toronto Health Partners (NYTHP) Ontario Health Team's (OHT) response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing to confirm North York General Hospital's (NYGH) full commitment to the North York Toronto Health Partners (NYTHP) proposal: *Compassionate team-based primary care for all*.

NYGH is one of the proud founding partners of the NYTHP and, as the acute care member of our OHT, we contribute in a variety of ways including providing key operational, and strategic support to the NYTHP and its initiatives (e.g., finance, communications and engagement, project management, privacy, HR, digital health, research and evaluation). We are also the transfer payment agency for our OHT's annual operational budget from Ontario Health.

A strong, integrated primary care system that supports all people, particularly those with the greatest health and social care needs, is the lynchpin of a connected care system - one that improves the health and wellbeing of the entire population and is sustainable for many generations to come.

Primary care is at the heart of NYTHP and has been central to our OHT's design since the beginning. North York is home to a strong and well-developed network of team-based primary care providers – Family Health Teams and Community Health Centres – who have a track record of sharing experience and expertise and delivering collaborative care to populations. Our Primary Care Network (built on the established NYTHP Primary Care Association), is made up of 230 primary care physicians.

As demonstrated by this EOI, NYTHP is proposing to leverage this provincial investment to bring team-based care to every person in our population of 500,000. The partners have detailed how primary care providers together with providers from community health and social care will attach the approximately 12,000 people who do not currently have access to primary care as well as extend team-based care across every neighbourhood, leveraging existing resources and investing strategically to expand team-based resources.

NYGH is supporting this proposal in a variety of ways, including through the full participation of the Department of Family and Community Medicine (DFCM) at North York General Hospital, Canada's largest community-based teaching site.

It is time to embrace bold ideas and demonstrate the impact that connected team-based care can have on the health, quality of life and experiences of individuals and entire communities. The success of the NYTHP and its vision of *Compassionate team-based primary care for all* can be a success for every part of the province and every Ontarian.

Thank you for your consideration. We look forward to continuing to partner with the Ministry of Health and Ontario Health to achieve a connected and convenient health system for all.

Sincerely,

Karyn Popovich
President and CEO
North York General Hospital

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – NYTHP's response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

On behalf of Circle of Care, I am writing to confirm our commitment to the North York Toronto Health Partners Ontario Health Team's (OHT) proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods. We are committed to working collaboratively as one team to increase access to care for all, and prioritizing the unattached, equity-deserving populations in our North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support of our entire OHT and Primary Care Advisory Council – anchored by our four existing primary care team-based models in North York: the North York Family Health Team, Flemingdon Health Centre, Unison Health and Community Services and Vibrant Healthcare Alliance.

As one of the organizations supporting team-based care expansion, we at Circle of Care are committed to support team-based care for the population of North York.

We are am proud to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Carey Lucki
Chief Executive Officer

Canadian Mental Health Association
Toronto

700 Lawrence Ave. W., Suite 480
Toronto, ON M6A 3B4
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F. 416-789-9079
E. info@cmhato.org
W. www.toronto.cmha.ca

June 12, 2023

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – NYTHP's response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing to confirm our commitment to the North York Toronto Health Partners Ontario Health Team's (OHT) proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of the fastest-growing neighbourhoods. We are committed to working collaboratively as one team to increase access to care for all and prioritizing the unattached, equity-deserving populations in our North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support. CMHA Toronto has a lot of experience working within collaborative teams, the most recent example being the Northwest pilot of the Toronto Community Crisis Service.

This proposal has the support of our entire OHT and Primary Care Advisory Council – anchored by our four existing primary care team-based models in North York: the North York Family Health Team, Flemingdon Community Health Centre, Unison Community Health Centre and Vibrant Healthcare Alliance.

As one of the lead organizations supporting team-based care expansion, we at CMHA Toronto are committed to supporting team-based care for the population of North York.

We are proud to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Michael Anhorn
CEO

Baycrest

June 12, 2023

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – NYTHP's response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

This letter confirms Baycrest Hospital's commitment to the North York Toronto Health Partners Ontario Health Team's (OHT) proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods. We are committed to working collaboratively as one team to increase access to care for all, and prioritizing the unattached, equity-deserving populations in our North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support of our entire OHT and Primary Care Advisory Council – anchored by our four existing primary care team-based models in North York: the North York Family Health Team, Flemingdon Community Health Centre, Unison Community Health Centre and Vibrant Healthcare Alliance.

As one of the lead organizations supporting team-based care expansion, we at Baycrest are committed to support team-based care for the population of North York.

On behalf of Baycrest Hospital, I am proud to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Deb Galet
Vice President, Long-Term Care, Ambulatory and Chief Heritage Officer

3560 Bathurst St. T: 416 785 2500
Toronto, Ontario W: www.baycrest.org
Canada M6A 2E1

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – NYTHP's response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing to confirm my commitment to the North York Toronto Health Partners Ontario Health Team's (OHT) proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods. I am committed to working collaboratively as one team to increase access to care for all, and prioritizing the unattached, equity-deserving populations in our North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support of our entire OHT and Primary Care Advisory Council – anchored by our four existing primary care team-based models in North York: the North York Family Health Team, Flemingdon Community Health Centre, Unison Community Health Centre and Vibrant Healthcare Alliance.

As one of the leads supporting team-based care expansion, we at the Freeman Centre for the Advancement of Palliative Care, North York General Hospital are committed to support team-based care for the population of North York.

I am proud to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Sandy Buchman MD CCFP (PC) FCFP
Freeman Family Chair in Palliative Care & Medical Director,
Freeman Centre for the Advancement of Palliative Care, North York General Hospital, Toronto
Professor, Division of Palliative Care, Department of Family and Community Medicine, University of Toronto

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – NYTHP's response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing to confirm our commitment to the North York Toronto Health Partners Ontario Health Team's (OHT) proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods. We are committed to working collaboratively as one team to increase access to care for all, and prioritizing the unattached, equity-deserving populations in our North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support of our entire OHT and Primary Care Advisory Council – anchored by our four existing primary care team-based models in North York: the North York Family Health Team, Flemingdon Health Centre, Unison Health and Community Services and Vibrant Healthcare Alliance.

As one of the organizations supporting team-based care expansion through our Integrate Care Solutions division of Bayshore, our organization is committed to support team-based care for the population of North York.

We are proud to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Karen Fisher

National Director, Community Partnerships
Bayshore HealthCare

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – NYTHP's response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing to confirm Saint Elizabeth Health Care's (SE Health's) commitment to the North York Toronto Health Partners Ontario Health Team's (OHT) proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods. SE Health is committed to working collaboratively as one team to increase access to care for all, and prioritizing the unattached, equity-deserving populations in our North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support of our entire OHT and Primary Care Advisory Council – anchored by our four existing primary care team-based models in North York: the North York Family Health Team, Flemingdon Health Centre, Unison Health and Community Services and Vibrant Healthcare Alliance.

As one of the organizations supporting team-based care expansion, we at SE Health are committed to support team-based care for the population of North York.

We are proud to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

John Yip,
Director

SE Health

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – NYTHP's response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing to confirm Closing the Gap Healthcare's commitment to the North York Toronto Health Partners Ontario Health Team's (OHT) proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods. We are committed to working collaboratively as one team to increase access to care for all, and prioritizing the unattached, equity-deserving populations in our North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support of our entire OHT and Primary Care Advisory Council – anchored by our four existing primary care team-based models in North York: the North York Family Health Team, Flemingdon Health Centre, Unison Health and Community Services and Vibrant Healthcare Alliance.

As one of the organizations supporting team-based care expansion, we at Closing the Gap are committed to support team-based care for the population of North York.

We are proud to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Yiannis Soumalias

Vice President, Partnerships and Business Performance
Closing the Gap Healthcare

June 15, 2023

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – NYTHP's response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing to confirm VHA's commitment to the North York Toronto Health Partners Ontario Health Team's (OHT) proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods. VHA is committed to working collaboratively as one team to increase access to care for all, and prioritizing the unattached, equity-deserving populations in our North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support of our entire OHT and Primary Care Advisory Council – anchored by our four existing primary care team-based models in North York: the North York Family Health Team, Flemingdon Health Centre, Unison Health and Community Services and Vibrant Healthcare Alliance.

As one of the organizations supporting team-based care expansion, we at VHA Home HealthCare are committed to getting communities through health challenges and creating accessible, quality care for all who need it. We look forward to leveraging our home and community care expertise and partnerships in the OHT to deliver on primary care on-site and off-site clinics, in-home visits in-person and/or virtually to provide the parallel ancillary health care services, in addition to consultation and education support for primary care outreach to those in most need of primary care services.

We are proud to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Susan Chang, MSc(OT), OT Reg.(Ont.), MHSc
Director, Health System Transformation
Strategic Solutions & Partnerships Department

VHA Home HealthCare
30 Soudan Avenue, Suite 600
Toronto, ON M4S 1V6
www.vha.ca

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: Compassionate team based primary care for all – Our response to Expanding and Enhancing Interprofessional Primary Care Teams EOI

Dear Anna

On behalf of North York Toronto Health Partners, I am so pleased to enclose our proposal in response to the EOI: Compassionate team-based primary care for all. Our proposal has been developed through support and collaboration of our entire OHT, which includes our Primary Care Network, and anchored by four existing team-based models in North York:

- North York Family Health Team (one of the largest in Ontario)
- Flemingdon Health Centre
- Unison Health and Community Services and;
- Vibrant Healthcare Alliance.

Additional organizations in our team participating as collaborators:

- Baycrest Hospital
- Bayshore HealthCare
- Canadian Mental Health Association Toronto
- Circle of Care
- Closing the Gap Healthcare
- Department of Family and Community Medicine, North York General Hospital
- Freeman Centre for the Advancement of Palliative Care, North York General Hospital
- Home and Community Care Support Services Central Region
- North York General Hospital
- VHA Home HealthCare
- SE Health

Today, less than 25% of our population of about 500,000 has access to team-based primary care. We know this is the best care for all. As such, our vision is to bring compassionate, team-based primary care to everyone in our community.

Our proposal will bring team-based primary care to the remaining 400,000 individuals across our 18 communities and attach an additional 12,000 equity-deserving, unattached patients in North York to Compassionate, team-based primary care.

We will achieve this by:

Enabling access for all, especially unattached

- Existing, well-established team-based models will expand capacity to serve new patients with wrap-around care
- No-barrier model – drop-in, mobile, virtual, welcoming spaces for people of all needs
- Community navigators (ambassadors) will support equity-deserving community members to access and navigate primary care
- Supporting communities with some of the largest number of seniors in the province

Redefining the "team" in team-based care

- One team that will work across our primary care network, FHTs CHCs and other practices and clinics collaborating together
- Care to include social determinants – social supports, wellness, prevention, healthy eating, all delivered with a culturally appropriate lens

Introducing enhanced primary care for priority groups

- NP-anchored model for step-up and step-down care: homebound, mental health and addictions, cancer survivorship, palliative, supporting individuals to thrive at home
- Ensuring everyone has access to mental health support to prevent escalation and the need for acute or institutional care

Training the next generation, evaluating, spreading and scaling

- Leveraging the largest community-based teaching site in the province
- Adding capacity through training learners in North York, for North York
- Evaluating, measuring and spreading through continuous innovation and quality improvement

On behalf of the Stewardship Council of North York Toronto Health Partners, we are confirming our wholehearted commitment to continuing to create a more Compassionate North York through Compassionate, team-based primary care for all to advance population health in our community and beyond.

Sincerely,

Ivy Wong
Director, OHT & Transformation
North York General Hospital
On Behalf of the Stewardship Council, North York Toronto Health Partners

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – North York Toronto Health Partners (NYTHP) Ontario Health Team's (OHT) response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing in support of the NYTHP OHT's proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

Primary care is the heart of NYTHP – our OHT's vision for integration starts with a strong foundation of team-based, connected primary care, available to everyone in our community.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods This proposal will increase access to care for all, and particularly the unattached, equity-deserving populations in our North York community through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support and collaboration of our entire OHT and Primary Care Advisory Council – anchored by our four existing team-based models in North York: the North York Family Health Team, Flemingdon Community Health Centre, Unison Community Health Centre and Vibrant Healthcare Alliance.

I am pleased to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Dr. Maria Muraca MD, CCFP, FCFP
Assistant Professor, University of Toronto
Medical Director, North York Family Health Team.
Co-chair Primary Care Advisory Council, NYTHP OHT

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – North York Toronto Health Partners (NYTHP) Ontario Health Team's (OHT) response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing in support of the NYTHP OHT's proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

Primary care is the heart of NYTHP – our OHT's vision for integration starts with a strong foundation of team-based, connected primary care, available to everyone in our community.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods This proposal will increase access to care for all, and particularly the unattached, equity-deserving populations in our North York community through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support and collaboration of our entire OHT and Primary Care Advisory Council – anchored by our four existing team-based models in North York: the North York Family Health Team, Flemingdon Community Health Centre, Unison Community Health Centre and Vibrant Healthcare Alliance.

I am pleased to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Dr. Rebecca Stoller MD, CCFP, FCFP
Assistant Professor, DFCM, University of Toronto
Co-chair Primary Care Advisory Council, NYTHP OHT

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: Compassionate team-based primary care for all – North York Toronto Health Partners (NYTHP) Ontario Health Team's (OHT) response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

On behalf of the North York Toronto Health Partners (NYTHP) Patient and Caregiver Health Council (PCHC), we wish to express our support for the NYTHP OHT's proposal in response to the EOI: Compassionate team-based primary care for all.

NYTHP is a partnership of 22 core partners, over 30 alliance partners, our Primary Care Network of over 230 primary care physicians, and the PCHC. NYTHP actively seeks patient, family and caregiver voices to create and deliver health and social care services, a more integrated system and positive experiences for all. Engagement and partnership are a permanent and integral part of our OHT. As the standing Council representing the patient and caregiver voice at NYTHP, our Members sit on every NYTHP Committee and at planning tables for our key OHT initiatives. The PCHC is embedded on the Primary Care Advisory Council where we work collaboratively with our primary care partners to co-design the primary care strategy of our OHT and to identify gaps and challenges faced by patients and caregivers.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of its fastest growing neighbourhoods This proposal will increase access to care for all, particularly the unattached, equity-deserving populations in our North York community through the development of a network of neighbourhood-specific integrated care teams.

This proposal has the support and collaboration of our entire OHT and Primary Care Advisory Council – anchored by our four team-based models in North York: the North York Family Health Team, Flemingdon Community Health Centre, Unison Community Health Centre and Vibrant Healthcare Alliance.

We know from lived experience that primary care is at the heart of patient-centred care. Our OHT's vision for integration starts with a strong foundation of team based, connected, respectful primary care, driven by principles of equity and available to everyone in our community. We are pleased to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Judy Katz, Patient Partner, NYTHP-PCHC Co-Chair
Dara Zarnett, VP, Circle of Care; Executive Champion for Engagement, NYTHP-PCHC Co-Chair
On Behalf of the NYTHP-PCHC Membership

TORONTO Public Health

Dr. Eileen de Villa
Medical Officer of Health

June 14, 2023

Ontario Health Review Team
EOI Interprofessional Primary Care

Dear Ontario Health Review Team:

On behalf of Toronto Public Health (TPH), I am pleased to express my support for the North York Toronto Health Partner's (NYTHP) proposal to expand team-based primary care for all people in its geographic area.

Toronto Public Health has had the opportunity to work closely with members of the NYTHP over the past few years, including on our successful COVID-19 vaccination effort, and I can attest to the broad and cohesive partnership and commitment to connected care for local residents.

In addition to my confidence in the NYTHP, I am very supportive of the proposed approach and the ability of the primary care partners to make significant progress on the goal of extending team-based primary care to all people in the geography, with a focus on unattached individuals.

The NYTHP has a robust network of existing primary care teams, including Family Health Teams, Community Health Centres and North York General's large academic Department of Family and Community Medicine, working together to coordinate and extend team-based primary care within all neighbourhoods. The NYTHP's Primary Care Network of over 230 physicians is a tremendous asset as well.

The focus on reducing barriers to equity-deserving populations is reinforced throughout the proposal design including community navigators, building on the NYTHP's utilization of ambassadors in underserved neighbourhoods, and no-barrier approaches including mobile, drop-in, and virtual services.

NYTHP's core partners include several social care organizations and this OHT has had success linking health, community, and culture-based services to address social determinants of health including food security and housing supports. It is exciting to see this proposal include strengthening linkages between primary care providers and community service providers to deliver wrap-around care.

The focus on specialized support for high-needs populations for whom integrated primary care is essential is another strength of the Compassionate team-based primary care for all proposal. Another valuable feature is the plan to leverage the unique skills of nurse

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practitioners to support populations as their needs change, including those with mental health conditions and addictions, and vulnerable older adults.

Toronto Public Health looks forward to continuing to grow our partnership with NYTHP and supports the vision of team-based care for all in North York.

Sincerely,

Eileen de Villa, MD, MBA, MHSc, CCFP, FRCPC
Medical Officer of Health

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Hon. Marco Mendicino
Member of Parliament / députée Eglinton-Lawrence

June 2023

Mr. Ben Vozzolo
Chief Executive Officer
Vibrant Healthcare Alliance
2398 Yonge St.,
Toronto, Ontario, M4P 2H4

Dear, Mr. Vozzolo:

I hope this letter finds you in good health.

I am writing to provide my support for Vibrant Health Alliance's ("Vibrant") application, in partnership with its Ontario Health Team, to expand team-based care in our community.

Vibrant Healthcare Alliance is an organization that facilitates a broad range of programs that not only provide essential healthcare services to our community but also work to improve the social determinants of health. For instance, they provide harm reduction services; a used needle drop box, safe drug use kits, safe sex kits, and naloxone. They also support survivors of gender-based violence and provide care for people living with disabilities in supportive housing. Vibrant also facilitates a range of physical and social activities that support the mental and physical health of our community.

These key social services that Vibrant provides to the midtown Toronto community come alongside the healthcare delivery that Vibrant provides as well. They employ a team of doctors, nurses, therapists, and many other types of medical professionals who support our community in a variety of ways. Vibrant's team of Personal Support Workers also provides a variety of everyday services to people with complex disabilities across the region.

Vibrant's stated values – Inclusiveness, Accountability, Excellence, and Collaboration – represent the key commitments that healthcare and service providers across the country strive to achieve each day. I am confident that Vibrant's expansion efforts will bring about positive change and inspire others to prioritize equitable healthcare.

***Ottawa*:** House of Commons / Chambre des communes, Ottawa, Ontario K1A 0A6 Tel: (613) 992-6361 Fax: (613) 992-9791
E-Mail / Courriel: marco.mendicino@parl.gc.ca
***Toronto*:** 511 Lawrence Ave W, Toronto, Ontario M6A 1A3 Tel: (416) 781-5583 Fax: (416) 781-5586

Thank you for your invaluable contributions to our community; I'm wishing you continued success with your important mission.

Sincerely,

Hon. Marco Mendicino
Member of Parliament, Eglinton-Lawrence
Minister for Public Safety

Ottawa**:** House of Commons / Chambre des communes, Ottawa, Ontario K1A 0A6 Tel: (613) 992-6361 Fax: (613) 992-9791
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Toronto**:** 511 Lawrence Ave W, Toronto, Ontario M6A 1A3 Tel: (416) 781-5583 Fax: (416) 781-5586

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Ali Ehsassi
Member of Parliament
Willowdale

The Hon. Sylvia Jones, Minister of Health
Ministry of Health
777 Bay St.
Toronto ON M7A 1Z8

June 14, 2023

Re: **Letter in Support for North York General Hospital (NYGH)'s Expression of Interest (EOI) to the Ministry of Health and Ontario Health**

Dear Minister Jones,

I am writing to you to support a response submitted by North York General Hospital (NYGH), along with the Ontario Health Team (OHT) and North York Toronto Health Partners (NYTHP), to the Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest.

As one of Canada's top-ranked hospitals, NYGH has played an essential role in caring for and elevating the well-being of the residents of our community for over 50 years. As NYGH serves nearly half a million people in North York and beyond, NYGH and its team are ready for the expansion of existing primary care and the creation of additional new teams for communities that are in need.

It is imperative to acknowledge that North York is among the fastest growing areas in Toronto, and this investment will certainly make a difference to enable NYGH and its team to provide crucial services to ensure everyone has the opportunity to primary care when they need it the most. Given NYGH's exemplary service to the community, particularly the most vulnerable amongst us, the members of the NYGH have the commitment, expertise, and knowledge to make this vision of integrated and accessible primary care a reality.

Thank you in advance for considering this letter as part of your evaluation process. Should you have any questions or concerns, please do not hesitate to contact my office.

Sincerely,

Ali Ehsassi

Ottawa
Room 502, Wellington Building, Ottawa, Ontario K1A 0A6
Tel.: (613) 992—4964 / Fax: (613) 992—1158

Constituency Office
115 Sheppard Avenue West, Toronto, Ontario, M2N 1M7
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HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA
Han Dong
Member of Parliament
Don Valley North

June 13th, 2023

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: Support Letter - *North York Toronto Health Partners'* response to Expanding and Enhancing Inter-professional Primary Care Teams EOI

I am delighted to voice my support for *North York Toronto Health Partners'* response to the Expanding and Enhancing Inter-professional Primary Care Teams Expression of Interest.

North York is one of the most diverse areas and fastest growing areas of the City. The population of my riding, Don Valley North, is experiencing significant growth due to new development, attracting new families, professionals, and seniors coming into the community in need of primary care.

As a leader in team-based primary care that brings together family physicians, nurse practitioners and a spectrum of disciplines to care for the health needs of individuals and families, the primary care providers of North York have a sound and exciting vision for how they will enhance.

Access to primary care, especially through inter-professional primary care teams, is crucial for the well-being of individuals, families, and communities. The demand for primary care is already substantial, particularly among those who lack or have inadequate access to regular services. With our growing population, driven by new residential developments, this local need will only escalate.

Given the context, I express my strong support for the North York Toronto Health Partners (NYTHP) Ontario Health Team's proposal in response to the EOI. The NYTHP has demonstrated its potential through the active commitment of health and social care organizations across the continuum, as well as the valuable involvement of patients and caregivers in the partnership. Moreover, the NYTHP's well-developed Primary Care Network, which includes over 230 primary care physicians, further reinforces their capabilities.

Thank you for considering the importance of this initiative and for your dedication to improving primary care services in our community.

Sincerely,

Han Dong, MP
Don Valley North

Constituency Office
250 Consumers Rd, Suite 1000, North York, Ontario, M2J 4V6
Tel: 416-443-0623

Ottawa Office
Room 654-180 Wellington Street, Ottawa, ON K1P 5B9
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Ontario
LEGISLATIVE ASSEMBLY

STAN CHO, MPP
Willowdale

Constituency Office:
111 Sheppard Ave. W.,
North York, ON M2N 1M7
Tel: 416-733-7878
Tel: 416-733-7709
Email: stan.cho@pc.ola.org

Toronto Office:
5th Floor, 777 Bay St.
Toronto, ON M7A 1Z8
Tel: 416-327-9200

June 14, 2023

Dear Minister Jones,

I hope this letter finds you well.

I'm writing in support of an Expression of Interest (EOI) submission your office should be in receipt of or receive soon from North York General Hospital (NYGH) and its Ontario Health Team.

My riding of Willowdale sits at the heart of NYGH's catchment area and my constituents rely on the hospital's services every single day, for everything from maternal to emergency care, to surgery and mental health support.

With Willowdale and the wider North York area experiencing considerable growth in recent years – a trend that is projected to continue for the foreseeable future – it's imperative that NYGH's primary care network has the support it needs to expand and deliver the myriad services it provides our community day in and day out, now and in the years ahead.

Supporting NYGH's primary care expansion plan conforms to the Ministry of Health's existing commitment to increase primary care teams and/or create up to 18 new teams for communities with the greatest needs – a key element of the provincial government's *Your Health: A Plan for Connected and Convenient Care.*

As MPP for Willowdale, I strongly support North York General Hospital's EOI submission and hope the Ministry of Health can help the NYGH team in their goal to provide better access to primary care for residents of our growing community.

Sincerely,

Stan Cho, MPP
Willowdale

CITY COUNCILLOR
Shelley Carroll 高雪莉
WARD 17 DON VALLEY NORTH

TORONTO
Toronto City Hall
100 Queen Street West, Suite A3
Toronto, Ontario
M5H 2N2

June 14, 2023

Anna Greenberg
Chief Regional Officer, Toronto and East Regions, Ontario Health

RE: North York Toronto Health Partners' response to Expanding and Enhancing Interprofessional Primary Care Teams EOI

North York is one of Toronto's most diverse areas, with the highest concentration of seniors and some of fastest-growing neighbourhoods.

To ensure that our residents, families, and communities are healthy, we need to guarantee them access to fulsome primary care, specifically an interprofessional primary care team. While the need for primary care is great today, this local need will only increase with our growing population. In Don Valley North, the ward where North York General Hospital is located, the population is projected grow by 30% in the coming years as a result of new residential developments.

Keeping in mind the needs of both current and future residents of Don Valley North, I strongly support the North York Toronto Health Partners (NYTHP) Ontario Health Team's proposal in response to the EOI. I have watched NYTHP play an essential role in supporting our community, particularly during the hardest years of the pandemic. I have full confidence in NYTHP's ability, especially given the active commitment of health and social care organizations across the continuum and of both patients and caregivers in the partnership.

Primary care has been central to NYTHP since its inception. The North York Family Health Team (FHT) and North York General's Department of Family and Community Medicine are founding members, and other FHTs, CHCs, and primary care providers are active participants in integration initiatives including primary care attachment and neighbourhood-based clinics. NYTHP also boasts a Primary Care Network of over 230 primary care physicians.

I am particularly excited about the potential of this proposal to increase access to primary care through a network of neighbourhood hubs connected to social and wellness services and supports. NYTHP is well-positioned to successfully deliver this comprehensive approach to connected care and demonstrate meaningful improvements in access, equity, and outcomes for populations served.

I believe that this proposal will enable NYTHP to continue making a difference to the health and wellbeing of the 500,000 people in our area and will serve as a foundation for advancing population health and a demonstration of connected care in Ontario.

Sincerely,

Shelley Carroll
City Councillor, Ward 17—Don Valley North

416-338-2650 • councillor_carroll@toronto.ca • shelleycarroll.ca

Councillor
James Pasternak
York Centre

Toronto City Hall
City Hall, 100 Queen St. West, 2nd Floor, A22
Toronto, Ontario M5H 2N2

June 9, 2023

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: Supporting North York Toronto Health Partner's Expression of Interest for the Ontario Health's Funding Application

I am writing to endorse North York Toronto Health Partners' (NYTHP) proposal, *Compassionate team-based primary care for all*, to support the Ministry of Health and Ontario Health's expansion of primary care for North York communities.

The model being proposed by the NYTHP partners will take full advantage of the team-based approach to primary care and extend this model to the neighbourhoods and groups who would benefit the most.

NYTHP is known for its strong primary care leadership and, with an existing Primary Care Network of nearly 250 physicians and the collaborative relationships between primary care, North York General Hospital, and home and community care providers, the Ontario Health Team is well-positioned to ensure all people and families are connected to primary care, close to home.

Through this provincial investment in primary care teams, NYTHP will be able to have an even greater impact on population health in North York, particularly for residents who face barriers today. This, in turn, will reduce the demand on the hospital and reduce avoidable visits to NYGH's Emergency Department (ED), which is among the busiest EDs in the Greater Toronto Area.

I strongly support NYTHP's efforts to create a more connected and compassionate health system for all, built on a strong network of primary care teams.

Sincerely,

James Pasternak
City of Toronto Councillor for Ward 6, York Centre
Chair of North York Community Council
Chair of General Government Committee

TORONTO

Councillor Josh Matlow

Ward 12, Toronto – St. Paul's
City Hall, 100 Queen Street West
2nd Floor, Suite A17
Toronto, Ontario M5H 2N2

Tel: 416-392-7906
Fax: 416-392-0124
councillor_matlow@toronto.ca
www.joshmatlow.ca

June 7, 2023

Mr. Ben Vozzolo
Chief Executive Officer
Vibrant Healthcare Alliance
2398 Yonge St.,
Toronto, Ontario, M4P 2H4

Dear Mr. Vozzolo,

I hope this letter finds you in good health.

I am writing to provide my support for Vibrant Health Alliance's ("Vibrant") application, in partnership with its Ontario Health Team, to expand team-based care in our community. Vibrant is an important part of our community, dedicated to its wellbeing and providing access to care to equity-deserving populations. I firmly believe that health equity is a fundamental right and crucial component of building healthier communities.

Disparities in healthcare are not new and have created considerable barriers for equity-deserving populations in accessing the care they need and deserve, and that has wide-ranging impacts on the physical, mental, and socioeconomic wellbeing of individuals and communities. I am, however, encouraged by the commitment of Vibrant to expanding access to primary care and allied health services. Not everyone has access to a family doctor and allied health care providers. Working together with its Ontario Health Team as a network of care teams of different providers who connect people to care when they need it, Vibrant will continue to

provide accessible, culturally safe, community access to primary care with connections to social and wellness supports.

By prioritizing populations with the greatest need, such as newcomers, people with complex health issues and physical disabilities and people with low income, Vibrant is breaking down the often-significant barriers these populations face when accessing healthcare, including financial limitations, geographical constraints, physical barriers, cultural disparities, and social determinants of health.

Again, I wholeheartedly support Vibrant's efforts to expand access to primary care and allied health services. Your initiative aligns closely with my own goals and values, and I am committed to advocating for policies and funding that support and strengthen these endeavors. Together, we can create a healthcare system that is truly equitable where every individual lives a healthy and fulfilling life regardless of their circumstances.

Please do not hesitate to reach out if there is any way in which I can further support your endeavors.

Wishing you continued success with your important mission,
Sincerely,

Councillor Josh Matlow
City Councillor
Toronto – St. Paul's
www.joshmatlow.ca

Mike Colle

Toronto City Councillor | Eglinton-Lawrence

416-338-0008
mikecolletoronto.com
councillor_colle8@toronto.ca

June 8, 2023

Mr. Ben Vozzolo
Chief Executive Officer
Vibrant Healthcare Alliance
2398 Yonge St.
Toronto, Ontario
M4P 2H4

Dear Mr. Vozzolo,

I am writing to provide my support for Vibrant Health Alliance's ("Vibrant") application, in partnership with its Ontario Health Team, to expand team-based care in our community. Vibrant is an important part of our community, dedicated to its wellbeing and providing access to care to equity-deserving populations. I firmly believe that health equity is a fundamental right and crucial component of building healthier communities.

Disparities in healthcare are not new and have created considerable barriers for equity-deserving populations in accessing the care they need and deserve, and that has wide-ranging impacts on the physical, mental, and socioeconomic wellbeing of individuals and communities.

I am, however, encouraged by the commitment of Vibrant to expanding access to primary care and allied health services. Not everyone has access to a family doctor and allied health care providers. Working together with its Ontario Health Team as a network of care teams of different providers who connect people to care when they need it, Vibrant will continue to provide accessible, culturally safe, community access to primary care with connections to social and wellness supports.

By prioritizing populations with the greatest need, such as newcomers, people with complex health issues and physical disabilities and people with low income, Vibrant is breaking down the often-significant barriers these populations face when accessing healthcare, including financial limitations, geographical constraints, physical barriers, cultural disparities, and social determinants of health.

Collaboration and coordination are essential to effectively addressing healthcare disparities and achieving sustainable change. Vibrant's dedication to working closely with other local health care providers and community health organizations demonstrates a strategic and integrated approach that will undoubtedly yield significant positive impacts.

Again, I wholeheartedly support Vibrant's efforts to expand access to primary care and allied health services. I am committed to advocating for policies and funding that support and strengthen these endeavors. Together, we can create a healthcare system that is truly equitable where every individual lives a healthy and fulfilling life regardless of their circumstances.

City Hall Office
100 Queen Street West, A20
Toronto, ON M5H 2N2

Constituency Office
2952 Dufferin Street
Toronto, ON M6B 3S9

Mike Colle

Toronto City Councillor | Eglinton-Lawrence

416-338-0008
mikecolletoronto.com
councillor_colle8@toronto.ca

Thank you for your commitment to health equity. I am confident that Vibrant's expansion efforts will bring about positive change and inspire others to prioritize equitable healthcare.

Please do not hesitate to reach out if there is any way in which I can further support your endeavors.

Wishing you continued success with your important mission.

Sincerely,

Mike Colle

Toronto City Councillor
Ward 8, Eglinton-Lawrence

City Hall Office
100 Queen Street West, A20
Toronto, ON M5H 2N2

Constituency Office
2952 Dufferin Street
Toronto, ON M6B 3S9

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

RE: *Compassionate team-based primary care for all* – North York Toronto Health Partners (NYTHP) Ontario Health Team's (OHT) response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing in support of the NYTHP OHT's proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

Primary care is the heart of NYTHP – our OHT's vision for integration starts with a strong foundation of team-based, connected primary care, available to everyone in our community.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods This proposal will increase access to care for all, and particularly the unattached, equity-deserving populations in our North York community through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support and collaboration of our entire OHT and Primary Care Advisory Council – anchored by our four existing team-based models in North York: the North York Family Health Team, Flemingdon Community Health Centre, Unison Community Health Centre and Vibrant Healthcare Alliance.

I am pleased to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

MD

12/12/23

Dr. Adam Dwosh

4256 Bathurst Street Suite 306
Toronto, Ont. M3H 5Y8
TEL: 416-222-3011 FAX: 416-221-3097

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

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Sincerely,

J Chad

Dr. Jeremy Chad, MD, MSc, CCFP
Family Physician, North York General Hospital
Lecturer, University of Toronto

NORTH YORK TORONTO HEALTH PARTNERS

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Chief Regional Officer, Toronto and East Regions
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Sincerely,

Dr. Jodi Sonshine

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

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Sincerely,

Steven Kahane BSc, MD, CCFP, FCFP
Assistant Professor, DFCM, University of Toronto
Lead Physician, Leslie Medical FHO

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

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Sincerely,

Dr. Kimberly Reiter

KReiter

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

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Sincerely,

Dr. Sheila Yuen

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

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I am pleased to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Prasanna
Patient and Family Advisor
Primary Care Advisory Council
NYTHP.

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

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North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods. I am committed to working collaboratively as one team to increase access to care for all, and prioritizing the unattached, equity-deserving populations in our North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods This proposal will increase access to care for all, and particularly the unattached, equity-deserving populations in our North York community through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

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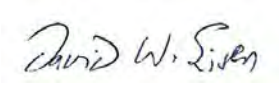
Sincerely,



David W. Eisen, MD, CCFP, FCFP
Associate Professor, University of Toronto
Chief, Department of Family and Community Medicine
Family Medicine Teaching Unit, 4S
North York General Hospital

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

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I am pleased to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Dr. David White
Professor, Department of Family and Community Medicine
Temerty Faculty of Medicine, University of Toronto
Past Chief, DFCM, North York General Hospital
Past President Canadian College of Family Physicians

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions
Ontario Health

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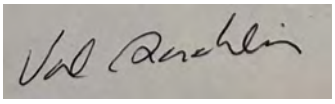
North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighborhoods. I/We am/are committed to working collaboratively as one team to increase access to care for all, and prioritizing the unattached, equity-deserving population in our North York Community. The collaboration Will be demonstrated through the development of a network of integrated care teams focused on neighborhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and Wellness support.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighborhoods. This proposal will increase access to care for all, and particularly the unattached, equity-deserving populations in our North York community through the development of a network of integrated care teams focused on neighborhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support and collaboration of our entire OHT and Primary Care Advisory Council – anchored by our four existing team-based models in North York: the North York Family Health Team, Flemingdon Community Health Centre, Unison Community Health Centre and Vibrant Healthcare Alliance.

I am pleased to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,



Dr. Val Rachlis
Past Chief, Department of Family and Community Medicine
North York General Hospital
Past President, Ontario College of Family Physicians

Family & Community Medicine
UNIVERSITY OF TORONTO

Temerty Medicine

June 16, 2023

Anna Greenberg
Chief Regional Officer
Toronto and East Regions
Ontario Health

Re: Compassionate team-based primary care for all – North York Toronto Health Partners (NYTHP) Ontario Health Team's (OHT) response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing in support of the NYTHP OHT's proposal in response to the EOI: Compassionate team-based primary care for all.

Primary care is the heart of NYTHP – the OHT's vision for integration starts with a strong foundation of team-based, connected primary care, and this is reflected within their leadership structure, where the Department of Family and Community Medicine (DFCM) is a key member of NYTHP's Stewardship Council.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods. I am committed to supporting North York as they increase access to care for all, prioritizing the unattached, equity-deserving populations in the North York community. The collaboration will be demonstrated through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

North York General's DFCM has 318 credentialed staff, and 150 of these physicians have Faculty Appointments at the University of Toronto. This is the largest group of Faculty Appointed family physicians in the University of Toronto Temerty Faculty of Medicine. These physicians are involved in providing clinical care, as well as actively teaching the next generation of Family Physicians and allied health professionals. They do this educational work in their offices, the ER, on inpatient floors, as well as through outpatient clinics and in patients' homes. In addition to clinical care and teaching, their FPs are involved in Research and QI projects and are active contributors to leading primary care research programs including UTOPIAN and POPLAR.

By bringing medical students into Family Medicine residency programs and training Family Medicine residents to become active FPs and teachers, the North York General DFCM is actively adding net new FPs into the system, building system capacity and attaching patients. Their unique skill-set in doing this makes NYGH and NYTHP an ideal place to invest in expanding team based care for all.

Sincerely,

Danielle Martin, MD MPP CCFP FCFP
Professor and Chair
Department of Family and Community Medicine
Temerty Faculty of Medicine | University of Toronto

NORTH YORK TORONTO HEALTH PARTNERS

Anna Greenberg
Chief Regional Officer, Toronto and East Regions

Ontario Health

RE: *Compassionate team-based primary care for all* – North York Toronto Health Partners (NYTHP) Ontario Health Team's (OHT) response to Expanding and Enhancing Interprofessional Primary Care Teams Expression of Interest (EOI)

Dear Anna,

I am writing in support of the NYTHP OHT's proposal in response to the EOI: *Compassionate team-based primary care for all*. NYTHP is a partnership of 22 core partners, over 30 alliance partners, a Patient and Caregiver Health Council and our Primary Care Network of over 230 primary care physicians.

Primary care is the heart of NYTHP – our OHT's vision for integration starts with a strong foundation of team-based, connected primary care, available to everyone in our community.

North York is one of Toronto's most diverse areas with the highest concentration of seniors and some of fastest growing neighbourhoods This proposal will increase access to care for all, and particularly the unattached, equity-deserving populations in our North York community through the development of a network of integrated care teams focused on neighbourhood-specific health needs. The teams would provide convenient, culturally safe, comprehensive care with connections to social and wellness support.

This proposal has the support and collaboration of our entire OHT and Primary Care Advisory Council – anchored by our four existing team-based models in North York: the North York Family Health Team, Flemingdon Community Health Centre, Unison Community Health Centre and Vibrant Healthcare Alliance.

I am pleased to support compassionate, team-based primary care for all as the foundation for advancing population health in our community and beyond.

Sincerely,

Signed by the Members of the North York Toronto Health Partners Primary Care Network

NORTH YORK TORONTO HEALTH PARTNERS

Dr. Alan Monavvari
Dr. Alisa Naiman
Dr. Allyson Merbaum
Dr. Amanda Yvonne Li
Dr. Barbara Erdelyi
Dr. Carol Muallim
Dr. Carol Silverstein
Cassandra Kwok, NP
Dr. Catherine L Kelley
Dr. Christy Starway
Dr. Daniel Yim
Dr. Danielle Manis
Dr. David Silver
Dr. Debra Birnbaum MD CCFP
Dr. Delia Curea
Dr. Doug Kavanagh
Dr. Gary ting-kay Mok
Dr. Susan Masters
Dr. David W. Eisen
Dr. Jasmine Yu
Dr. Jeffrey Habert
Dr. Tsz-Tim Timothy Li
Dr. Edward Jesin
Dr. Eva Knifed
Dr. Farnoosh Soltani
Dr. Harvey Blankenstein
Dr. Irene Hwang
Dr. Jen Stulberg
Dr. Jennifer Hunter
Dr. Jeremy Chad
Jessica Lau, NP
Dr. Jodi Sonshine
Dr. Jordana Sacks
Dr. Karen Grace Stel
Dr. Keith Hoi-kwun Wong
Dr. Kimberly Reiter
Dr. Lisa Millstein
Dr. Lisa Tarshis
Dr. LiYang Liu

NORTH YORK TORONTO HEALTH PARTNERS

Managing Partners, North York Family Medicine Centre & North York Health Centre Inc.
Dr. Melissa Singer
Dr. Micheline Thifault
Dr. Michelle Greiver
Dr. Michelle Janutka
Dr. Mihaela Codruta Cordos
Dr. Naomi Driman
Dr. Noel Allan Rosen
Dr. Risa Bordman
Dr. Ron Phillipson
Dr. Sadaf Arbab-Tafti
Dr. Sandy Buchman
Dr. Sarah Kronis
Dr. Sharanya Rajendra
Dr. Sharonie Valin
Dr. Shashi P Devi
Dr. Sheila Yuen
Dr. Steven Kahane
Dr. Susan Parker
Dr. Teresa Goldenberg
Dr. Zane Brickman

NORTH YORK FAMILY HEALTH TEAM

NORTH YORK TORONTO HEALTH PARTNERS
COMPASSIONATE NORTH YORK

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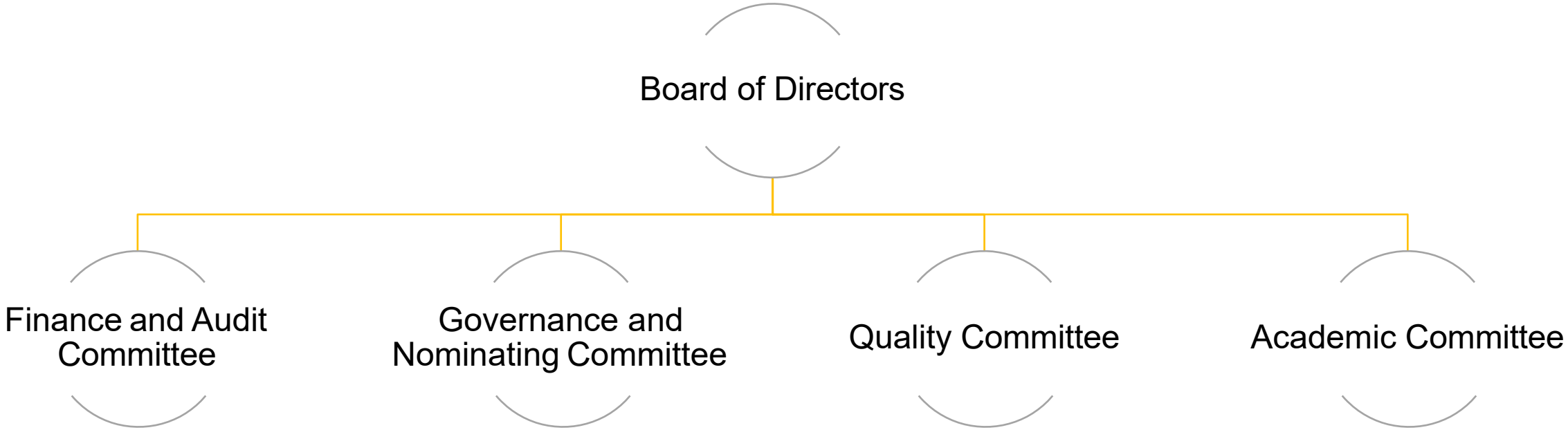
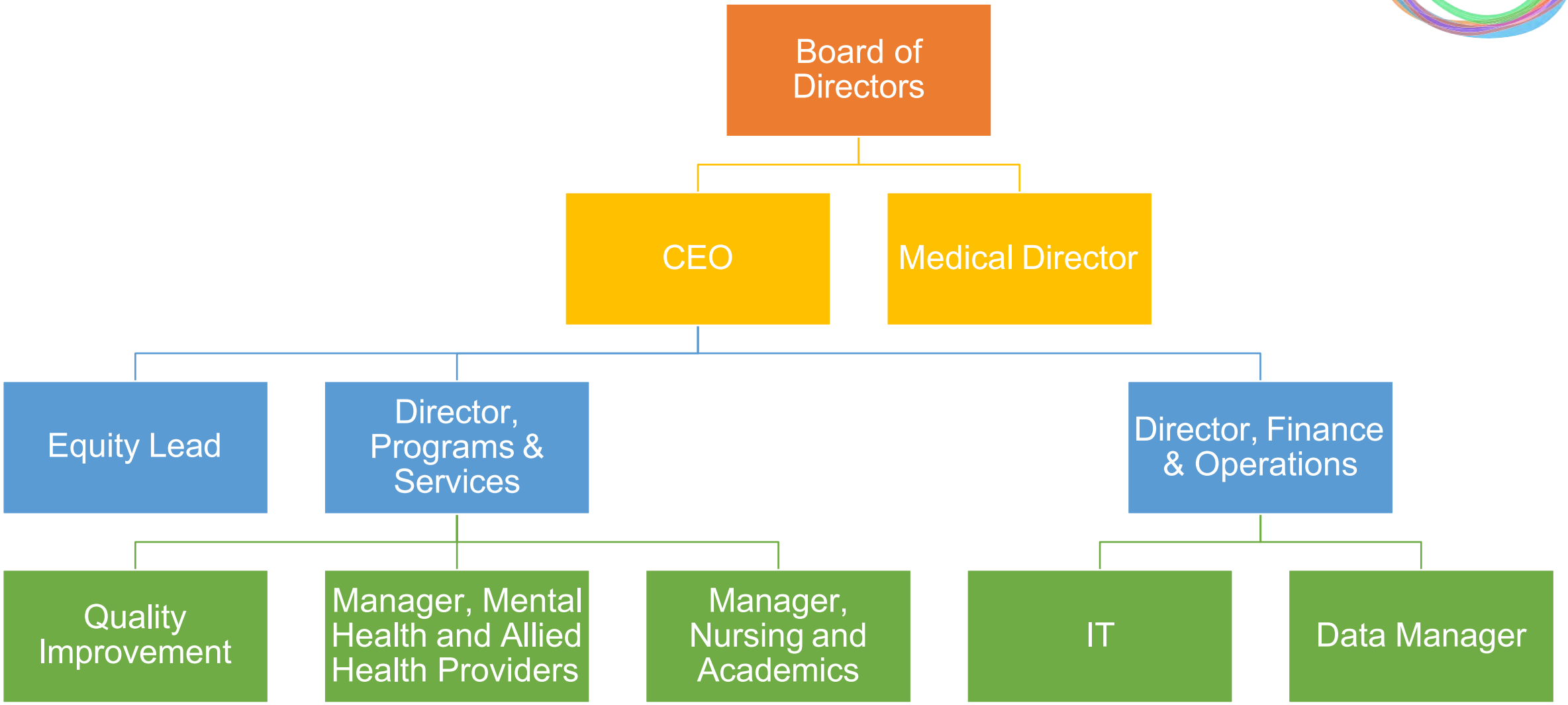
Click on the Appendix to Navigate.

Appendix A - NYFHT Organizational Chart

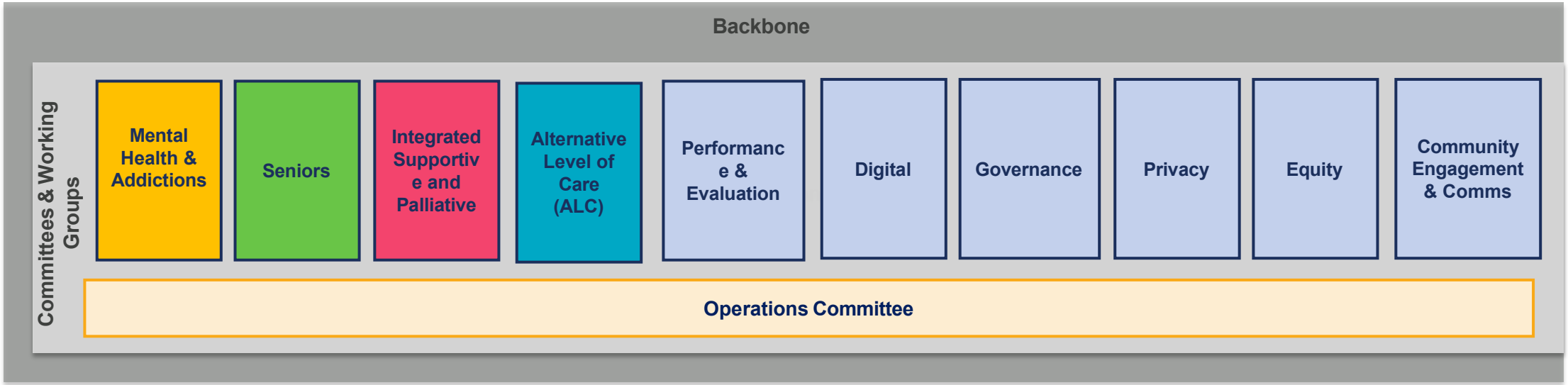
Governance Chart



Organizational Chart



NYTHP Organizational Structure



Appendix B -

NYFHT Policy - Director Recruitment & Nomination.

North York Family Health Team **BOARD POLICIES & PROCEDURES**	**Policy Number: GP – 4.1** **Approval Date: March 2014** **Date Reviewed: October 2018** **June 2022** **Review – 3 Years**
SECTION: Governance Process	
SUBJECT: Director Recruitment and Nomination	

A. Introduction

Effective governance requires that the Board of Directors possess an appropriate mixture of skills, experience, personal qualities and diversity.

B. Policy

The Board of Directors recognizes the critical importance of ensuring that the Board of Directors possesses the necessary and appropriate skills, experience, personal qualities and diversity to exercise appropriate governance oversight over the North York Family Health Team's (NYFHT) affairs.

C. Procedures

1. The Board shall identify qualified candidates through the following process:

a. The number of Board vacancies shall be determined annually and the necessary criteria to fill those vacancies will be identified by conducting a skill-set and gap analysis. If a vacancy on the Board of Directors occurs between AGMs, then the Nominating Committee will convene to consider whether a replacement Director should be nominated. If the AGM is more than six months away, the vacancy should be filled as soon as possible. If the AGM is less than six months away then the vacancy can be filled at the AGM. In the event that a replacement Director is nominated, the new Director will be appointed by the Board of Directors and would fulfill the remaining term of the vacancy.

b. Directors shall be evaluated based on their performance. Renewal of their election or appointment shall not be automatic.

c. An open call for nominations shall be made and interested parties will be encouraged to submit written applications in the form attached hereto as Schedule A.

d. Applications shall be submitted to the Chair of the Nominating Committee and shall be reviewed by the Nominating Committee.

e. A short-list of candidates shall be developed by the Nominating Committee of those individuals who meet the criteria as identified by the Board.

f. The Nominating Committee shall recommend candidates to the Board for its approval.

Through the nomination and election process, the Board will select Directors according to their skill, experience and personal qualities, seeking a balance within the Board of skills and experience, while considering any unique or special requirements of NYFHT at the time.

NYFHT shall seek to ensure that the Board is appropriately representative of the membership's mix of age and gender and include Board members who have or have had demonstrated Board experience and/or formal training in directorship and/or governance.

The skills, experience, knowledge and personal qualities that the Board will use to select potential directors are set out below:

Personal Qualities: Ideally, every Board candidate shall possess the personal qualities and behavioral skills set out below. It may not be possible to assess whether every candidate has every one of these qualities. Furthermore, not every candidate need have all of them. However, it would be relevant if any candidate either lacked a number of them, or demonstrably had all or most of them.

(a) *Integrity*: including a commitment to understanding and fulfilling the duties and responsibilities of a Board member, and maintaining knowledge in this regard through professional development; putting the NYFHT's interests before any personal interests; being transparent and declaring any activities or conduct that might be a potential conflict, and maintaining Board confidentiality.

(b) *Commitment and Interest*: A visible commitment to NYFHT's on-going success; prepared to invest the time necessary to ensure that success.

(c) *Objectivity and independent-mindedness*: Capable of forming own judgments and opinions and presenting them clearly; able to ask tough questions and persist in requiring answers; able to argue a minority position.

(d) *Willingness and ability to listen and ask questions*: Attentive and respectful listener, asks questions in a way that contributes to the debate.

(e) *Flexibility*: Open to new ideas, forward thinking, and responsive to change.

(f) *Informed judgment*: Able to focus on the important issues, and base decisions on sound principles, rational analysis, and common sense.

(g) *Perspective*: Possessing broad knowledge and experience, and able to apply them to discussions.

(h) *Analytical and innovative thinker*: Possessing well-developed conceptual thinking and problem-solving skills; able to develop innovative approaches and solutions to problems

Eligibility (Consistent with Charitable Law):

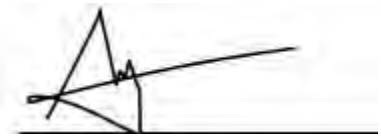
a. No employee or paid contractor is eligible to serve on the Board in a voting position
b. No individual who otherwise benefits financially from the NYFHT, either directly or indirectly (includes being a shareholder in a company that receives payments from the NYFHT, or being married to someone who receives payments form the FHT) is eligible to serve in a voting position on the Board. Financial benefits include in-kind financial benefits provided by the NYFHT such as space or resources, but does not include general support provided to all physicians
c. Must not have a signed lease or signed agreement that pertains to the lease with NYFHT
d. Be in good standing and not have any outstanding monies owing to the NYFHT
e. Have all candidates sign a written declaration that he/she meets the eligibility requirements

Skills, Experience and Knowledge:

The Board will reflect a complementary mixture of skills, experience and knowledge, as set out in this matrix:

	Skill Categories	**Directors: Who has what?**	**Prospects: Who has what?**
Financial performance	Qualifications and experience in accounting or finance		
Policy Development	Ability to identify key issues for NYFHT and develop appropriate policies to define parameters within which NYFHT should operate		
Risk Management and compliance oversight	Ability to identify key risks to the NYFHT in the areas of legal and regulatory compliance, and to develop and monitor risk and compliance systems		
Board Governance	Knowledge and experience in best practice governance structures, policies and processes,		

	Skill Categories	Directors: Who has what?	Prospects: Who has what?
	previous Board experience, (particularly in the not-for-profit context), community mindedness		
Information technology	Knowledge and experience in the strategic use of information management and information technology, particularly collection of health data and electronic health records, and including personal information privacy and security risk management.		
Executive management	Experience at an executive level including ability to appoint/evaluate the CEO; oversee strategic human resource management and employee relations; and oversee large-scale organizational change.		
Physician & Clinical Leadership/ Practice	Knowledge and experience in clinical leadership, practice and governance; safety and quality standards of service delivery in primary health care, and associated performance measurement and reporting		
Strategic Planning	Knowledge and experience in identifying and setting direction for an organization that optimizes future potential		
Program Planning	Knowledge and experience in services necessary to achieve mission including how services will be financed and evaluated (Board Governance level).		



Justin Gould, Board Chair

SCHEDULE A
NORTH YORK FAMILY HEALTH TEAM DIRECTOR RECRUITMENT / NOMINATION POLICY

NORTH YORK FAMILY HEALTH TEAM
Application for Membership to the Board of Directors

Instructions:

To apply to be a member of NYFHT's Board of Directors, please complete this form and submit your completed form, along with a copy of your current CV, by mail, fax or email to:

Chair, Nominating Committee,
North York Family Health team,
*(*insert information)*

*For more information about the application process, please contact (*insert information).*

APPLICANT CONTACT INFORMATION:

Surname:	First Name:
Home Address:	
Home Phone Number:	Business Phone Number:
Email Address:	
Preferred Method of Contact:	

ELIGIBILITY CRITERIA AND CONDITIONS OF APPOINTMENT:

(a) Directors must be at least 18 years of age.
(b) Undischarged bankrupts are ineligible to serve as Directors.
(c) A Director may not be a an employee of NYFHT.
(d) A Director is expected to commit the time required to perform Board and Board committee duties.
(e) Directors must fulfill the requirements and responsibilities of their position – for example, preparing for and attending board and committee meetings, upholding their fiduciary obligations and working cooperatively and respectfully with other Board members. Directors must comply with legislation governing NYFHT, NYFHT's by-laws, policies and procedures, and all other applicable rules.

(f) Directors must sign a declaration confirming their agreement to adhere to their

fiduciary duties, and board and corporate policies.

CONFLICT OF INTEREST DISCLOSURE STATEMENT:

Directors must avoid conflicts between their self-interest and their duty to NYFHT. In the space below, please identify any relationship with any organization that may create a conflict of interest, or the appearance of a conflict of interest, by virtue of being appointed by the Board.

KNOWLEDGE, SKILLS AND EXPERIENCE:

The Board seeks a complementary balance of knowledge, skills and experience. Please complete schedule A of this form.

Please indicate your current occupation or past, if retired:

Please list current or prior board experience (including any Board Committees that you have served on):

What areas of Board work are of particular interest to you?

Please describe any involvement you have or had with other health care groups or community agencies within your community.

Please provide at least 3 references.

DECLARATION:

By submitting this application, I declare the following:

(a) I meet the eligibility criteria and accept the conditions of appointment set out above;
(b) I have read and agree to comply with the following (attached to this application):
   I. Position Description – Board of Directors' Duties and Expectations of a Director
   II. Board Code of Conduct
   III. Conflict of Interest Policy
(c) I certify that the information in this application and in my resume is true.

Signature: _____ Date: _____

Application for Membership to the NYFHT Board of Directors
Schedule A - Knowledge, Skills and Experience

Please indicate your areas of knowledge, skills and experience by checking off the relevant boxes in the table below. It is not expected that you possess knowledge, skills and experience in all the areas set out in the table. Please indicate only those areas that apply to you.

Accounting / Finance ☐ Basic ☐ Intermediate ☐ Advanced	**Information Technology** ☐ Basic ☐ Intermediate ☐ Advanced
Board & Governance ☐ Basic ☐ Intermediate ☐ Advanced	**Legal** ☐ Basic ☐ Intermediate ☐ Advanced
Business & Management ☐ Basic ☐ Intermediate ☐ Advanced	**Quality & Patient Safety Management** ☐ Basic ☐ Intermediate ☐ Advanced
Clinical Practice & Leadership ☐ Basic ☐ Intermediate ☐ Advanced	**Quality & Performance Management** ☐ Basic ☐ Intermediate ☐ Advanced
Health Care Administration & Policy ☐ Basic ☐ Intermediate ☐ Advanced	**Human Resources Management** ☐ Basic ☐ Intermediate ☐ Advanced
Strategic Planning ☐ Basic ☐ Intermediate ☐ Advanced	**Risk Management** ☐ Basic ☐ Intermediate ☐ Advanced

Appendix C-

NYFHT Patient Advisory Collaborative. Terms of Reference.

North York
Family Health Team

North York Family Health Team
Patient Advisory Collaborative (PAC)

TERMS OF REFERENCE

PURPOSE

The North York Family Health Team's (NYFHT) Patient Advisory Collaborative (PAC) is a volunteer group of individuals who are consulted on various matters to enhance and improve the North York Family Health Team patient experience and engagement through partnership and collaboration.

GOALS & OBJECTIVES

- To embed the patient/family member perspective in various initiatives including but not limited to, strategic plans, quality improvement activities, and program development and co-design opportunities.
- To provide patient centric strategies for improving patient/family engagement and communication, programs and services and overall patient care.
- Provide input/feedback on recommendations about health care access and/or service delivery improvements from the patient/family perspective.
- Provide input into the development of policies related to patient engagement and patient centered care.

ACCOUNTABILITY

To the NYFHT Leadership Team. Chair will provide updates regarding PAC activities to Leadership Team at biweekly NYFHT Leadership Meetings.

Patient Advisory Collaborative (PAC) Committee

- The PAC Committee will consist of 8-12 individuals (patients, family members, care providers, and/or community members) who have expressed an interest in the Patient Advisory Collaborative, and have completed the application and orientation process
- NYFHT Quality Improvement Specialist
- Other NYFHT team members as needed

Patient Advisory Collaborative (PAC) Resource Pool

- The PAC Resource Pool will consist of individuals (patients, family members, care providers, and/or community members) who have expressed an interest in the Patient Advisory Collaborative and have completed the application and orientation process
- Members of the Resource Pool will be invited to participate in projects on an as needed basis, based on their interest, skill set, and ability to commit to the project timeline
- There is no limit to the number of individuals in the Resource Pool

Patient Advisor Requests

- NYFHT patients, staff and physicians who would like to engage a patient advisor in a project (QI, program development, patient experience/engagement, activity) can complete and submit

a **NYFHT Patient Advisor Engagement Form** describing their project and time commitment

- The information contained in the form will be shared with the committee members and resource pool members for consideration; those interested in the project can inform the PAC chair

MEMBERSHIP SELECTION

- Those who indicate an interest in becoming a PAC member will be encouraged to explore this opportunity in a conversation with the Quality Improvement Specialist (QIS). If both agree that this opportunity is a good fit in terms of interests and skills, the perspective PAC member will be invited to complete the Membership Conditions below. The QIS may seek input from other members of the organization regarding PAC membership at any point in the process.

MEMBERSHIP CONDITIONS

- Acknowledge/sign Confidentiality Agreement
- Acknowledge/sign Conflict of Interest Agreement
- Participate in an introductory orientation session

OPPORTUNITIES AND RESPONSIBILITIES

- Contribute ideas and suggestions that will enhance patients' engagement in health service planning and decision-making
- Advise/provide input regarding how best to meet the evolving healthcare needs of our diverse community
- Participate in communications (e.g., email) as requested
- Attend and participate in meetings/teleconferences
- Tell their story and share their point of view, but be able to objectively listen to and appreciate the views of others
- Assist in co-designing and evaluating new NYFHT programs/services by bringing patient and family perspectives
- Provide input into patient education materials
- Participate in committees as needed and as able
- Participate in developing patient experience strategies and/or activities
- Assist in improving the quality of health services provided
- Submit any agenda items to the Chair in advance of meetings
- Review meeting materials in advance
- Regarding meeting attendance, if a member misses three consecutive meetings, the Chair or Co-Chair will connect with them to determine whether they're able to continue in their role

CHARACTERISTICS OF A SUCCESSFUL ADVISOR

- Demonstrate a non-judgmental and positive attitude
- Respect diversity of community and perspectives
- Work collaboratively with other patients, family members and healthcare providers
- Confident in speaking and interacting with others in a group-based setting
- Excellent listener with solution focused approach to problem solving
- Ability to use their personal experiences constructively
- Ability to see beyond their own experience
- Able to commit a minimum of one year to the role

North York
Family Health Team

CHAIR/CO-CHAIR

Co-Chairs will consist of the Quality Improvement Specialist and one other PAC member (patient/family member/community member) who is a member of PAC.

Given this committee was newly established in September 2022, we will not elect a PAC Member Co-Chair until March 2023 at the earliest, and September 2023 at the latest.

ROLE OF CO-CHAIRS

- Organize and communicate meeting schedule to committee
- Create and circulate meeting materials (agendas, minutes, supporting documents)
- Facilitate the meetings in a manner that enables respectful, accessible, robust discussions and encourages participation of all PAC members
- Advance the work of the PAC and ensure alignment with the PAC Purpose, Goals & Objectives
- Liaise with NYFHT Leadership Team to provide regular updates regarding PAC activities
- Facilitate annual committee evaluation and election of new PAC Member Co-Chair
- Vet committee applicants, and orient new committee members as required
- Act as a PAC representative outside of PAC meetings as needed (i.e., Board Meetings, Team Meetings etc.)

CO-CHAIR ELECTION PROCESS

A new PAC Member Co-Chair will be elected on an annual basis. PAC Members can self nominate or nominate another member.

COMMITTEE MEETING FREQUENCY

Meetings will be scheduled to occur monthly; meetings may be cancelled if the Chair/Co-Chairs determine there is insufficient meeting material to warrant a meeting. The Quality Improvement Specialist will aim to send out the meeting materials as early as possible, ideally, one week prior to the meeting date.

Approved by:

_____

Executive Director, NYFHT
Date:

References:

William Osler Health System:
https://www.williamoslerhs.ca/en/visiting-us/resources/pfac-tor_Remediated.pdf

The Centre for Family Medicine Family Health Team:
https://family-medicine.ca/images/Patient-and-Family-Advisory-Council-Terms-of-Reference.pdf

South East Toronto Family Health Team:
https://www.afhto.ca/wp-content/uploads/A1-Implementing-a-Patient-Advisory-Council-in-An-Academic-FHT.pdf

Alberta Health Services:
https://www.albertahealthservices.ca/assets/info/pf/pe/if-pf-pe-patient-advisory-tor.pdf

Appendix D-

Nursing Roles and Responsibilities.

North York
Family Health Team

North York Family Health Team

Registered Nurse

New Hire Handguide

Updated December 2022 (Accuro/PSS)

RN Roles and Responsibilities

The role of the Primary Care Team is a unique part of the health care system:

In primary care, the physicians have long-term relationships with patients. A long-term perspective and understanding of patients' care and thus, prefer more information than less. This can prevent misunderstandings, miscommunications, and will greatly improve patient care outcomes.

General Information

- Welcome to the NYFHT!
- Before getting started, it is helpful to be comfortable with the EMR, Accuro/PSS (more information on this at the end of the document)

Office Management and Flow:

Office specific: In some offices, the front staff/clinical admin/office assistant may do the following, in others, this may be a part of the RN role. Please check with your office as to who is responsible for the following:

- Pertinent vitals for incoming patients
- Checking vaccine fridge temperatures and document readings (in AM and PM)
- Managing INRs that come in (through EMR)
- Supporting and assisting with immunizations

On your day to day…

1. Come in and check voicemails.
2. Return urgent calls/triages (people who are returning calls about tasks can wait provided their tasks are NOT urgent but otherwise, calls pertaining to triages that may need consulting with physician, fitting in same day or sending to ER take priority over other voicemails)
    a. Check with the physician if you are unsure about the priority of a task
3. Check tasks and messages on the EMR→ call all urgent tasks/messages FIRST
4. If a task requires repeat testing, ensure the physician has or will be completing the correct requisition(s) and ordering the appropriate test(s). Do NOT create a requisition without an explicit order from the physician
    a. **Depending on your specific office's procedures (check with them about which options they allow):** The patient can **pick the requistion up**, it can be **faxed**, or they can have it **mailed**
5. Periodically check that no new voicemails have come in, try to listen to them sooner than later to ensure not urgent
6. **Maintain accurate, concise, confidential documentation for each patient encounter**
7. **Collaborate in patient care with other providers within the circle of care**

Daily

Telephone Encounters

- Telephone triage – patients may call in with various questions/concerns. Conduct a detailed phone assessment, communicate conversation to most responsible physician (MRP), collaborate on a care plan and follow up with patient
    - More information on Telephone Triage can be found in the "Indirect Patient Care" section
- Provide health promotion and education, disease prevention and management, medication management, investigations, next steps, counseling patients and families across the continuum of health care
- Providing counseling surrounding abnormal results and any follow up and/or tracking as needed

***Important Notes about Patient Communications:

1. When speaking with patients they may request results outside of those assigned to the RN to discuss. **Before disclosing results (normal or otherwise) that were not assigned to discuss, speak with their physician first.** You can advise the patient that you can see the results are in and will have the physician review them and will follow up once you know more.
2. **Gather information during triage calls and propose the plan you are considering to the physician <u>before</u> making recommendations to the patient**. This would include advising patients to take meds (OTC or otherwise), suggesting physio or any other treatment.
3. If you have any verbal conversation about a patient where the physician advises a plan or treatment to be relayed to the patient, **<u>document</u>** the interaction through a message or response to task (which ever is appropriate for the situation) and note it as: "as discussed with…". Consider it a verbal order and document it and send it to the physician so they also have record of it.
4. The physicians welcome questions! Do not be afraid to ask. When in doubt, ASK! They are happy to advise. This includes clarification for unclear tasks.
5. There may come a time where a treatment plan or recommendation from the physician is not compatible with best practices/most recent guidelines. In these cases, collaborate with the physician and provide context as to why you may have a different perspective/approach and together decide on the best plan for the patient. It is important to feel comfortable with any advice/recommendations you are relaying to the patient.

Health Maintenance

- Assist in the completion and maintenance of health records and other necessary documentation. This includes updating the CPP with lifestyle, risk factors, preventative health screening, medications, allergies, vaccinations/immunizations, medical/surgical/family history
- EMR Maintenance: Alert and Global Messaging systems

Public Health

- Manage public health immunization program (ordering immunizations, maintaining vaccine fridge)

Team and Communication

- Participate in NYFHT committee assignments and NYFHT staff meetings
- Keep team up to date regarding FHT related initiatives; changes to immunization programs etc.
- Support the learning of all learners i.e. residents, students, interns, locums

QI

- Work collaboratively with the team in the development, implementation, and monitoring of priority program initiatives
- See QI details under “Indirect Patient Care” section

Weekly

- Order and maintain publicly funded vaccine supply

Monthly

- Attend RN/NP/PA and FHT Team Meetings- each held every quarter, usually Thursdays
  - Note these days on your schedule
  - Inform all team members in advance of these meetings
  - Consider blocking 30 minutes before meeting is to start to ensure all triages/urgent tasks are completed or followed up on
  - Upon return from these meetings, share all updates/information impacting patient care and best-practices with the office team
- Maintain clinic environment and inventory: ensuring optimal operation of equipment (including emergency meds kit, O2, etc.), monitoring controlled substances according to the policies and procedures of the FHT.
  - **Each office has an emergency box which contains equipment and meds for an emergency**
  - There is a glucometer with strips and lancets, an oxygen tank with nasal prongs, face masks and non-rebreather masks
  - There are meds in the box that need to be checked **monthly** for expiration
  - Please update the log sheet/documentation to reflect expiry dates
  - If something is 1-2 months from expiring, please inform the appropriate provider
  - Epi-pens have to be ordered through the pharmacy and can take time to come in so please give enough time for this
- Maintain NRT stock for CAMH’s STOP program; including submitting documents for your location

Yearly

- Organize yearly flu shot clinics

Direct Nursing Patient Care

Before Each Visit

- Begin visits by asking what their concerns are and try to triage, gather as much information as possible, and document this
- Use “RN encounter” (Accuro) or “SOAP Note” (PSS) for progress notes when other templates/custom forms are not applicable
- Update the Preventative Care Band (Accuro)/Preventative Care Toolbar (PSS) and other areas of the CPP when applicable

Common Types of In-Person Visits

Patients in office for fever/cough/cold/feeling unwell

- Check temperature
- For babies/children, check weight as well

For older adult/frail patients

- Check weight
- Check BP

For Blood Pressure Visits

- Usually they need 3-5 readings on the BP machine (depends on the machine in the office)
- Show the physician the BP readings and document all readings (Accuro: open the vitals, document the average in the main section and all readings in the notes section below; PSS: document these vitals in a note)

Driver’s License Physicals

- Height
- Weight
- BP
- Urine dip for protein and glucose
- Snellen eye exam (if RN in office is requested to complete this)
- Scan forms once completed by physician to chart

Preventative Health Review (PHR) (if this is something your office has the nurse supporting) will need:

- Height
- Weight
- BP
- Check their immunizations (Please see Adult Immunization section for specific guidelines)
    - **Vaccines are considered a medication order. Please check with the MRP BEFORE administering any vaccines if an existing order is not present**

- Review the patient's preventative care screening and ensure they are up to date (Please see Preventative Screening Timelines section for specific guidelines)
- **Office specific: Some offices may conduct the health teaching related to these visits. Use the appropriate template in the EMR to guide these visits.**
- And if they need a PAP (once every 3 years if normal after age 21-25 if sexually active) (check CPP under the 'Preventative Care' band/Preventative Care Toolbar or the virtual chart (Accuro) under cytology/pap as sometimes the CPP is not updated)

Diabetes Visits

- **Assessment**:
  - Height
  - Weight
  - Blood pressure (BP target is SBP of 130 or less and DBP of 80 or less)
- Prep documentation (see EMR Tips and Tricks for details)
- **Review Labs**
  - For most patients, the target HbA1C is 7 or less. This may vary with elderly frail patients where less tight control/management may be pertinent. You can use the Canadian Diabetes Guidelines and the range calculator to find the ideal range for a patient (see CDS/External Links section at the end for more).
  - LDL is targeted to be under 2 or 50% reduction from baseline. For those aged 40+, the current guidelines recommend starting a statin or increasing statin dosing.
  - Cr and eGFR are important to monitor as well- normal ranges do not differ from those without diabetes but need closer monitoring with each blood check especially if on medication that may be damaging/require adequate renal function to work appropriately. Monitoring these values and trends can also provide valuable information related to microvascular complications of diabetes.
  - We check ACR (albumin-creatinine ratio) yearly unless abnormal or a change in interventions and target is under 2. If over 2, speak with physician about an ACE-I or an ARB.
  - Add when the patient's last ECG/EKG was done. If normal, this is repeated q3-5 years. If no recent ECG, discuss with the physician and they will decide if it is necessary.
- Review diet- sometimes we do a full diet recall of the past 24-48 hours so we can provide education
  - Discuss spacing between meals
  - High fibre
  - Plate model
  - Snacks and foods with a low glycemic index
- Review activity
  - Recommendations are 30 mins, 5x/week (150mins/week) and 2-3 days of resistance exercise

    - There are great resources for those with reduced mobility to do resistance exercises in their chair at home (see CDS link/External Resources for more links)
- Review diabetes related medications
    - Any medications for blood glucose control and their doses
    - Medications for BP
    - Medications for cholesterol
    - ASA (mixed evidence so okay to document if they are on it but speak to physician before recommending it for ANY patient)
        - Can use tools on Diabetes Canada to decide if this is necessary
- Preventative Care Management
    - **Foot checks**- we check the feet of those with diabetes at least once per year and more frequently depending on the score
        - This is documented in the CPP (Accuro) or within the clinical note (PSS)
        - Recall training with Tiffany for this. EMR message her if you have questions
        - If you cannot find pedal pulses, always check posterior tibial and use doppler if available in office. Inform the physician and discuss if arterial doppler ultrasound needs to be ordered
    - **Eye checks for retinopathy**- yearly eye exams for patients with diabetes are covered by OHIP
        - Ask about when the last eye exam was and make sure it included diabetes related assessments (i.e. dilated eye exam)
        - Update the CPP (Accuro) or within the clinical note (PSS)
        - If overdue, prompt them and document this interaction
    - **Immunization Review**
        - Tdap/Td
        - Pneumovax23/Prevnar 13 (speak with physician)
        - Shingrix
        - Flu shot
- Consideration of FHT Referrals During DM Visits
    - After seeing patients, consider if they may benefit from additional support from the FHT programs and services
        - Example: though you are providing education and guidance in the patient's management of their diabetes, if they continue to require additional teaching, consider referral to DEP or individual services
        - As you assess the patient's mental health status during each visit, consider if they may benefit from additional mental health supports
            - Sleep and stress are important components for managing blood glucose levels and if those variables are impacting a patient's progress, would they benefit from CBT-I or SW
        - If their lipids continue to be uncontrolled and they decline/do not tolerate statins, consider referral to Heart Health program or RD for individual counselling
        - Many patients will have multiple comorbidities and have confusion, restrictions, concerns surrounding polypharmacy

        - Consider consulting with pharmacist
        - Example: patient has poorly controlled DM but also has poor kidney function, is elderly and does not want to see an endo for insulin. Pharmacy can advise which medications are safe to give with poor kidney function that will be safe for an elderly patient without risking hypoglycemia
    - Further instructions on how to create a referral can be found in the EMR Tips and Tricks
- **Office specific:** After seeing the patient, consult with the physician and give all information reviewed. Some offices may prefer to just review your notes before they see the patient.
    - If repeat bloodwork is required, speak with the physician about obtaining the requestion

For Well-Baby Visits

- **Assessment**:
    - Weight (clothes off and DRY diaper unless 18 months or older, then just shoes off)
    - Height (can use exam table to mark the top of head and heel of foot and measure that distance)
    - BP is done for those 4 years and older
    - Head circumference until 18 months at the widest part above the ears
- Document the measurements, check the growth chart to make sure measurements were accurate and growth is stable
- Review their immunizations (follow the Childhood Immunization Guidelines for spacing and which are given at what age found in CDS/External Resources section)
    - Check with physician before administering in case there are contraindications
    - More information on Childhood Vaccines found below
- Documenting the visit:
    - Depending on the age, open the **Rourke/Grieg assessments.** Each age group will have different normal limits so it is important to become familiar with these. Review pertinent items with the parents including:
        - Concerns
        - Feeding
        - Sleep
        - Intake/output
        - Supplementation with Vit D
        - Screen time
        - Socialization
    - Complete the **Nipissing** for the appropriate age group for development – if concerns, notify the physician before they see the patient

For Newborn Visits

- Ask parents for hospital discharge papers

- Add historical birth weight, height, and head circumference to chart and change to the date of birth for this entry
    - **At today's visit: Weigh the baby IN A DRY DIAPER, complete a head circumference at this age also and document this for today**
    - Calculate % of weight loss by using the following formula:
        - [(birthweight-current weight)/birthweight] x100
        - **Flag to the physician if not**:
            - Back to birthweight by 10-14 days old
            - Not gaining at least 20g/day
            - % weight loss should not be more than 10%

Urinary Tract Infections

- Using the NYFHT Medical Directive, we are able to see uncomplicated, adult female patients with suspected UTIs who meet specific criteria (please become familiar with this directive in detail)
- Documentation:
    - Accuro: In the drawer under the heading "Urinary Tract Assessment" which will help guide the visit
    - PSS: Use the "UTI" Stamp/Custom Form
- If the patient is being seen in person, ask the patient for a urine sample and use the Chemstrips to check the urine for primarily leukocytes, blood, nitrites, and protein
        - Document these findings in the appropriate section of your EMR
        - Once you have completed all the closed ended questions, assess the patient's temperature in clinic and CVA tenderness
        - After the visit, speak with the MRP and discuss if a requisition for the urine to be sent to the lab for testing is appropriate
        - Ensure to start each visit by documenting some information about when the symptoms started and with what before diving into the yes/no questions. Important to gather the background before completing the assessment.
    - If the patient is being triaged for a UTI over the phone, they will not likely be able to provide a sample
        - Collect all information and history using the same UTI template/custom form
        - After the visit, speak with the MRP and discuss if a requisition for the urine to be sent to the lab for testing is appropriate
- Ask about known and suspected med allergies and inquire about their preferred treatment plan (i.e. treat now or wait for culture results)
    - Let them know that their urine may be sent for culture and we will get the results in 48 hours usually (or the following Monday if sent on a Friday)
    - If symptoms are severe, we usually want to treat so make sure their pharmacy information is correct on file
        - Accuro: In the patient tab on Accuro, under "demographics"
        - PSS: Under demographics under "preferred pharmacy"
    - In those cases, the physician will usually start with a broad-spectrum antibiotic and if the culture ends up being resistant to what it grows, the patient will be notified so we can change the prescription

- Some patients may prefer to hold off on treating until the results come back if the symptoms are mild – this should be documented in the encounter note
- After you finish seeing the patient, speak with the primary or covering physician
  - If you are worried about the patient, they have risk factors and/or are complicated, you will need the physician to assess per the Medical Directive
- **This directive does not cover the RNs for seeing male patients, however, male patients can be assessed for UTI as done above by the RN but the patient must be seen by the physician- cannot be an RN only visit even if uncomplicated/no risk factors per FHT Medical Directive**

Ear Syringing

History:

- Ask if they are having any ear pain or have been recently unwell (including fever)
- Ask about itchiness
- Reduced or loss of hearing/tinnitus
- Balance concerns or dizziness
- Onset of symptoms
- Specify which ear(s)
- Ask the patient if the used any oil to loosen the wax (or other OTC options)
- Do they wear hearing aids? Use Q-tips? Wear earbuds often?

Assessment:

- Assess ear canals with otoscope- consider what is visible, what is not, is the tympanic membrane visible/translucent/opaque? Is there any exudate? Any redness? Any swelling?
- Before beginning any procedure-if they have not oiled, wax may be challenging to remove and may risk damaging the tympanic membrane by syringing so proceed with caution and use your clinical judgement if it is safe to proceed
  - If you are unsure, ask the physician to assess
- Assess the lymph nodes for swelling/tenderness in and around the ear and with movement of the pina

Procedure:

1. Before beginning, review the procedure including risks:
   - Failure to remove the wax
   - Otitis externa- inflammation of the external ear canal
   - Otitis media- middle ear infection
   - Perforation of tympanic membrane
   - Pain/discomfort/discomfort/vertigo
   - Worsening of ringing in ears (tinnitus)
2. Obtain verbal consent and document this consent in the encounter note
3. If the membrane is visible and/or exudate is present- **Do not syringe**
4. Assemble the syringe (if necessary), ensure a receptacle is under the ear to catch water/wax that drains out

5. Pull the pina up and out, orient the tip of the syringe to the outer entrance of the canal
6. Use warm water when flushing
7. Start slow- if you are not making much progress after 3 flushes, consider asking the patient to oil and return to clinic in 3-5 days. Use your clinical judgement.
8. There may be times where the wax has dislodged and just needs to be "scooped" out using a curette for this to GENTLY remove the dislodged wax. These should NOT be inserted beyond point of visibility nor directly into the dislodged wax as this can push it in further
9. Reassess the ears between flushes for progress and to ensure no redness, swelling or exudate present
10. Wipe down all equipment with Cavi-wipes or wash with soap and water
11. Document!

Health Teaching After the Visit:

- Remind patients to avoid using Q-tips inside the ear
- If they are prone to this happening often, they can use oil or peroxide prophylactically to avoid build-up
- Avoid using earbuds or other foreign objects in the ear
- Return to clinic if developing any difficulty hearing, pain, or ringing in the ear(s)

MOCAs

In-person:

- Before the visit, look in previous notes and chart and see if the patient had a previous MoCA and review the scores
- There are different versions, the scripts and scoring sheets can be found online
- There is a script FOR EACH VERSION- Do not go off script, it is meant to be worded the way it is written
- Score the test after the patient has completed it, try to speak clearly and loudly and avoid distractions
- Make sure patients have their glasses and hearing aids when administering these tests
- Unfortunately, there is a limitation when distributing this test to those with a language or education barrier but do your best
- Scan all completed MoCAs on to the patient's chart
- Write a note in the chart indicating anything that stands out and include information about language and environment so the physician is aware of any reasons for the results
- Consult with the physician after scoring (they should always be booked after being given the test)

By Telephone:

- If you are conducting a MoCA by phone, you can use the same version of the MoCA that we use for those visually impaired. This is called "Blind MoCA" – this has its own script and adjusted scoring

- Document this in the patient's chart- if you are working remotely, you can create a macro/stamp to document their responses to each section (since there will be no drawing associated)
    - consider completing a paper version and scanning into chart when you are next in office. Do not do this at home as PHI should not live outside of the EMR
- Review the results with the physician

Wound Care

- When removing sutures or staples, keep in mind that the timeline the hardware is meant to be in-situ will vary depending on the site. Consider consulting with the primary physician of the patient BEFORE removing anything. A rough timeline is below:
    - Face: 3-5 days
    - Neck: 7 days
    - Scalp: 7-10 days
    - Arms: 7-10 days
    - Trunk: 10-14 days
    - Legs: 10-14 days
    - Hands/feet: 10-14 days
    - Palms/soles: 14-21 days

History:

- Document using a macro/stamp the length and location of the laceration or incision, any redness, swelling, exudate that may be present
- Document the date of injury/surgery
- Assess pain (including medication and bowel relief), ambulation, follow-up with surgeon, mobility aids

Assessment:

- Assess the wound and report any concerning findings to primary physician before removal
- If okay to proceed, begin by cleansing the wound- the product you use may differ depending on the orders/type of wound care necessary
- Document any care done and include as much detail as possible
    - For suture/staple removal, include the number of each that was removed, if the edges were well approximated, length and location of the laceration or incision, any redness, swelling, exudate
    - When removing staples from joints, ensure the wound is well approximated before beginning. Remove every other staple to ensure the incision does not dehisce. Apply steri-strips as you go if necessary (i.e. high tension areas)

Health Teaching:

- Advise when/what to monitor for signs and symptoms of infection- redness, swelling, discharge, heat, increase pain, difficulty ambulating, wound edges coming apart, fever

Follow-up:

- Schedule phone/in person follow up as necessary

Immunizations for Babies, Children and Youth

BEFORE ADMINISTERING ANY VACCINATION

- Check immunization schedule if administering a publicly funded vaccine
- Check appropriate spacing of vaccine
    - This may include vaccines given in a series
    - This may include when/how to space live from non-live vaccines or live from other live vaccines
- If you have questions about an immunization safety and interactions between other medications, you can call the pharmacist and ask
- If the parent was receiving immunosuppressive therapy/biologics, this may augment the vaccine schedule, speak with the physician before administering ANY LIVE VACCINES (including oral Rotarix/Rotateq)
- If you have questions about schedule or need to obtain immunization records for a child, call Toronto Public Health (or the Public Health Unit in their residing area)
- The Public Health booklet found online includes a “catch-up schedule recommendations for school aged children”
    - Review this with the physician before beginning administration

Determining Needle Length and Administration Route

- For infants 2 months- 12 months, most IM injections are given in the anterolateral thigh
- After 12 months, most IM injections are given in the deltoid and subcutaneous injections are given in the upper arm
- The needle length will be based on the size of the infant’s thigh/arms. For larger thighs, use 1” and for skinnier thighs use 5/8”. For deltoid injections for children, 5/8” is usually sufficient, but judge each child individually
- No more than one IM shot per muscle (if the child needs 2 IM shots, they go into different arms/thighs depending on age) but 1 IM and 1 SC injection can be given in the same arm as they are different routes

Common Childhood Vaccines, Routes, and Health Teaching

- Pediacel
    - This is given for diphtheria, tetanus, pertussis, HIB, inactive-polio
    - This is a non-live vaccine given IM beginning at 2months (series: 2 months, 4 months, 6 months, 18 months)
- Prevnar-13
    - This given for 13 strains of pneumonia commonly present in young children and older adults
    - This is a non-live vaccine given IM beginning at 2 months (series: 2 months, 4 months, 12 months)
- Rotateq/Rotarix

    - This is given to prevent rotavirus- intestinal virus that can cause severe dehydration in young infants
    - It is a **live** oral vaccine given beginning at 2 months (series: 2 months, 4 months, 6 months (Rotateq is a 3 dose series, Rotarix is a 2 dose series))
    - Health teaching: parents should practice good hand-hygiene when changing diapers up to 1 week after child has received this vaccine
- MMR
    - This is given to prevent measles, mumps, and rubella
    - It is a **live** vaccine given SC at 12 months (there is one brand where this may be offered IM or SC)
    - Health teaching: The child may experience a rash at the vaccine site – ensure not spreading and provide teaching on red flags for anaphylaxis
- Men C-C
    - This is given to prevent meningococcal infections
    - This is a non-live vaccine given IM at 12 months
- Varicella
    - This is given to prevent varicella infection (chicken pox)
    - It is a **live** vaccine given SC at 15 months
    - Health teaching: The child may experience a chicken pox -like rash at the vaccine site and can happen up to 4 weeks post-vaccination – ensure rash not spreading and provide teaching on red flags for anaphylaxis
- MMRV
    - This vaccine is a combination vaccine and given to prevent measles, mumps, rubella, and varicella
    - The child must have received both individual MMR and varicella vaccines BEFORE they receive this combo vaccine
    - This is a **live** vaccine given SC at 4-6 years old
    - Health teaching: The child may experience a chicken pox -like rash at the vaccine site and can happen up to 4 weeks post-vaccination – ensure rash not spreading and provide teaching on red flags for anaphylaxis
- Adacel-Polio
    - This vaccine is given to prevent tetanus, diphtheria, pertussis, and inactivated polio
    - This is a non-live vaccine given IM at 4-6 years old
- Adacel
    - This vaccine is given to prevent tetanus, diphtheria, and pertussis
    - This is a non-live vaccine given at age 14-16

Expected Post-Vaccine Effects

- After effects of vaccines to inform parents of:
    - Mild fever
    - Crankiness
    - Tiredness
    - Loss of appetite

- Redness, tenderness and swelling at site
- More fussy

**if very lethargic, difficult to console, or febrile > 38 degrees C, or having difficulty breathing, parents should take the child to the ER immediately

Grade 7/8 Vaccines (typically given by Toronto Public Health in School)

- Men ACYW
  - This vaccine is given to prevent meningococcal infections from strains A, C, Y, and W
  - This is a non-live vaccine given IM when in grade 7/8
- Hep B
  - This vaccine is given to prevent hepatitis B
  - This is a non-live vaccine given IM when in grade 7/8 (series: if started on time, given at 0 and 6 months)
- HPV-9
  - This vaccine is given to prevent human papilloma virus in 9 strains
  - This is a non-live vaccine given IM in grade 7/8 (series: if given on time, given at 0 and 6 months)

Common post-vaccination side effects to counsel patients/parents on:

- Redness/swelling at the vaccine site
- Low grade fever 1-2 days after vaccine (can treat with acetaminophen or ibuprofen)
- Malaise, headaches, and low energy

Immunizations/Injections for Adults

BEFORE ADMINISTERING ANY VACCINATION

- Always review previous vaccine reactions/contraindications and spacing before administration of any vaccine/injection
- Live Vaccines:
  - MMR and Varicella vaccines **<u>cannot</u>** be given to women who are pregnant or are intending to conceive within the next 4 weeks
    - Before giving ANY live vaccines to women of child bearing age, please review the contraindication for pregnancy or becoming pregnant x 1 month and document this interaction. **Offices may have a policy for signed consent, if they do, please ensure consent is signed by the patient and scanned into their chart**

- Other live vaccines: MMR, Varicella, MMRV, Zostavax (Shingles)
- **Live vaccines are not safe to administer to those who are immunocompromised including those on immunocompromising therapies (i.e. chemo, biologics), those who are HIV+ and those who are asplenic**
- Live vaccines must be spaced out from other live vaccines by at least 1 month (sometimes more depending on the vaccine so please see minimum interval guidelines)
- Sometimes vaccine spacing can be complex, collaborate with a pharmacist and the MRP to decide how to best approach the vaccine plan if you are uncertain

Injections

- Ask if any previous reactions to injections
- Administer IM or SC to appropriate situation
- These will be documented as an EMR encounter note only, NOT in their immunization record

Common Adult Injections

- Testosterone
  - Always check the orders for each patient to know how much testosterone to give and frequency of their injections
  - **Office specific:** Offices typically store these serums for the patient. Check with your office as to where these are kept.
  - You will need to use a large gauge needle to draw the serum up as it is quite thick. Usually, 18G is needed.
  - When administering, usually need a longer needle at 22G and 1.5” (this may differ depending on resources available in office, check with the physicians)
  - They are given IM into the gluteal muscle
  - Inject slowly as the fluid is thick and will take some time to administer
  - Check previous administration site (left or right glute) and alternate between sites
- B12
  - These serums are also usually kept in the office
  - Most patients will get these shots every 2-4 weeks
  - Check when last dose was and what their orders are for dose and frequency
  - They are given IM into the deltoid muscle (alternate between L and R deltoids- check previous notes for last site given)
- Depo
  - This shot is given as a birth control method
  - It is given in the gluteal muscle every 3 months (can also be given in the deltoid if preferred by the patient).

        - Always check that it is being given between 10 weeks at the earliest and 13 weeks at the latest (see when last dose was and ensure it is within the appropriate time frame)
            - If being given after 13 weeks, you need a negative urine BHCG and permission from primary physician before administering
            - Book the patient's next shot for 10-13 weeks from then
    - Prolia
        - This is a medication called Denosumab injection
        - It is indicated for those with post-menopausal osteoporosis and decreased bone resorption
        - It is injected SC and comes in a preloaded syringe
        - It is given once every 6 months
        - Due to its mechanism of action, it is important that patients taking Prolia ensure they are getting 1200mg Calcium **from their diet** and 1000-2000IU Vit D OD to prevent hypocalcaemia
        - If they are not, side effects will be similar to those with hypocalcaemia (muscle and joint pains, jaw pain, abdominal pain)
        - Review the importance of dietary calcium and direct them to the Calcium Calculator on Osteoporosis Canada if they need to look into their calcium intake
    - Allergy Shots
        - Please ask about previous reactions before administering (i.e. itchiness, redness, shortness of breath)
        - All information about injection schedule is included in the box with each patient's individual vaccine from the prescribing Allergist
        - The shot is given SC, alternating arms between visits
        - After giving the shot, have the patient wait for 15 mins in the waiting room
        - After 15 mins, assess the site for post-reaction and document this as well
        - Monitor for induration size, redness, itchiness. Make sure NO shortness of breath from injection before they are discharged home
        - Document location and reactions

Adult Immunizations

Always review previous vaccine reactions/contraindications and spacing before administration of any vaccine

- Tdap/Td
    - Given every 10 years from age 14 onward
    - Tdap contains pertussis protection so should be given at least once in adult life
    - Also given if exposed to possible or confirmed tetanus
    - Also given in pregnancy (Tdap only for this) at 27 weeks or later
    - Not a live vaccine that is given IM

- Pneumonia Vaccines- Pneumovax-23 and/or Prevnar-13
    - Patients who are 65 and older, are covered by OHIP to have Pneumovax-23

- Patients who are 18 and over that have diabetes, are covered to have Pneumovax-23 and will need another booster AFTER age 65
- Some of the physicians prefer select high-risk patients to have two different pneumonia vaccines and **the order of the shots matters**
    - It should be given as PREVNAR-13 **first** and then 8 weeks later, Pneumovax-23
    - IF the patient already had Pneumovax-23 within the past 12 months, they need to wait a **full year** since that shot before getting Prevnar-13 to ensure maximum efficacy

**Prevnar-13 is not covered by the government EXCEPT under very specific criteria

- Shingrix
    - These shots are recommended for those age 50 and up
    - This is a non-live vaccine given IM in a two-dose series (first and second dose should be 2-6 months apart)
    - For those 65-70 years of age, this is now an OHIP covered vaccine
    - Evidence has shown a greater efficacy in this immunization versus the old Shingles vaccine called Zostavax in both preventing Shingles and preventing the post herpetic neuralgia
    - Health teaching: Local reactions can be quite severe including redness, swelling, pain, malaise. Early data suggests that 30% will experience flu-like symptoms for 24 hours so remind patients to plan accordingly
    - If chickenpox (varicella) status is unknown, speak with the MRP before administering this vaccine
- Travel Vaccines
    - Most offices do not carry travel vaccines so patients requesting travel vaccines should be directed to the Passport Health Clinics or Travel Clinics around the city
    - As these are not OHIP covered, they will be charged a consultation fee in addition to the cost of the vaccines themselves
    - Remind patients that immunization series needed for travel should be done well in advance of planned travel as they can take up to 2 weeks to become effective and a series may include up to three doses so the more doses given before travel, the better the protection

School Forms and Immunization Updates

- Check their forms and CPP
- Look into their chart and search immunizations or for previous records as many times they have older charts where their previous shots are documented

Common Tests/Vaccines for School Forms

- TB Skin Tests
    - Patients may need a 1 or 2 step TB skin test for work, school, or volunteering
    - Tubersol is used for these tests and 0.1mm of fluid is inserted **intradermally** to the forearm

        - Before administering ask if they have had a BCG vaccine in the past (though this is not a contraindication for a TB skin test)
        - Ensure they have NOT had a live vaccine x 1 month and do NOT give a live vaccine until step 2 is completed and read as it can interfere with results
        - Patients must return to office to see the RN for the TB skin test to be read within 48-72 hours. If they are over this time, they need it re-done. Do not book these visits on Thursdays for this reason.
    - For those needing 2 steps, they will need to come in 1-4 weeks after Step 1 is inserted for Step 2 to be inserted
    - When patients come for a reading, feel the **entire** injection area for an <u>induration</u> which is a bump under the skin, not the red area
        - Mark the border for the induration and measure it with the calipers in the office
        - When documenting, record as the actual mm measurement and then interpretation (positive vs negative)
            - POSITIVE RESULT IS 10MM OR MORE (for most) and requires a chest x-ray for comparison and must be ordered by the physician
            - A measurement of more than 5 mm could be considered a positive result for specific populations
            - If the result is positive on the first step, even if they need two steps, proceed to chest x-ray
            - If result is negative, move on to Step 2 if required
            - Document results in notes and CPP
    - If opening a new box of TUBERSOL in the fridge, mark the date it was opened and **the vaccine is good for 30 days**
- MMR or Varicella
    - If they need an MMR or Varicella booster and are female of child baring age, see above section on live vaccines*
- Sometimes you will need to track down immunization records for school aged children or adults
    - There are the different Public Health regions and nursing lines for immunizations. Call the appropriate region and ask for the immunization record to be faxed to you
    - Parents/patients can also call the immunization lines themselves to complete this
- When results cannot be found and/or proof of immunity is needed (many times this is needed for Measles, Mumps, Rubella, Varicella and Hep B), titres will need to be ordered
    - Speak with physician for order
    - This type of order requires a normal blank lab requisition where these titres are added to “other tests” and the Hep B immune status can be found just above this

        - A Public Health requisition will also be needed for MMR, Varicella and Hep B titres
        - These titres take 10-14 days to come back from Public Health and patients need to be aware of this
        - If patients need proof of immunity after getting an MMR, varicella, or Hep B booster, ask them to wait 4-6 weeks **after** getting the booster before getting bloodwork drawn to ensure the results are reflective of the booster
    - Once forms done, **SCAN ALL DOCUMENTS**
    - **Office specific:** Patients can then take originals AFTER scanned

INDIRECT (Telephone) PATIENT CARE

INRs (Office Specific)

- Patients on Warfarin/Coumadin for a-fibrillation or heart valve replacement will need their INR assessed regularly to ensure their medication has a therapeutic effect
- Physicians may send a task/message when the results of an INR are in
- Once you receive the task- review the dosing changes and when the INR should be repeated next
- Call the patient and review this information and document the interaction. Review if they have been taking their meds as prescribed, document if any missed doses, conduct dietary counseling on high vit K foods that may impact their INR results
- Some patients get repeat bloodwork drawn from home. Please ask them or check their chart and from there fax the new INR req with the date of their next due bloodwork draw

in the comments and fax to LifeLabs Housecall (number is in the address book on the EMR)
- Some patients who go to the lab for their bloodwork will need req with repeats- this is ordered by the physician and the patient can pick this up from office or it can be mailed **(office specific)**

Telephone Triages

- Many incoming calls to the Nursing Line will be triages – urgent triages should be addressed first
- **Before advising patient of any interventions (other than ER if they are unstable of course), discuss with the physician. This includes any meds, treatments, recommendations**
- If you find yourself on a call and are unsure of what questions to be asking, use the Adult and Pediatric protocol binders in the office
- You can also create macros/stamps for common triage complaints to ensure you ask all pertinent information before discussing with the physician (feel free to email Nureen for more information on how to best make these and utilize them!)
- Always write ALL triages as a message to the appropriate physician or covering physician
- After you triage, decide if it is urgent, please flag the message as urgent/asap (there is a drop down for priority setting) and send to appropriate bodies
- If it is urgent, please connect with the physician directly and inform them
    - If you had a verbal conversation with the physician, still document "As discussed with MRP…" and include all recommendations and send to them also so there are no miscommunications
- Follow up with the patient as appropriate and necessary!

Referrals for NYFHT Programs and Services

- You may find in various situations that you need to make a referral to the NYFHT for various programs/services
- RNs can refer to most of the programs except: De-prescribing, Mental health triage for psychiatric consult (ie with the psychiatrist Dr. Feder), NP Homebound (should be in collaboration with MRP as they need to provide contact information), and Obesity as a Chronic Disease
- Considerations for Referrals
    - Example 1: During diabetes appointments a patient may benefit from seeing the DEP team if their A1C continues to be uncontrolled
        - There is both an option for the classes (which we HIGHLY recommend a patient attend at least once) and individual counselling which includes a visit with the Registered Dietician, Pharmacist and/or RN
    - Example 2: Patients may have elevated LDLs/TG when reviewing results in tasks or during a diabetes visit and may benefit from seeing the RD
        - There are again two options: individual consult or Heart Health Program
- The more information you can include for referrals the better

- Once you have entered all information needed, provide the patient the phone number for 707 at 240 Duncan Mills and they are expected to initiate the referral. Include the appropriate extension.
- Once the referral has been created in the EMR, sending to reception will depend on EMR:
    - For Accuro users- right click the referral in the Encounter Notes and “Send Task”. The recipient needs to drop down and change to 707 and the reception group needs to be selected. Click send.
    - PSS users- after the custom form referral has been made, include pertinent lab values/ information by selecting “green bar”. CTL+SHIFT+F to fax (you will have the option to include the CPP from this pop-up screen). Add the receipt based on the address book in your office. The number should be: 416-494-8525. Click fax.

Tasks/EMR Messages from the Physicians

- On Accuro you will find tasks from the doctors regarding results or follow up. On PSS you will see these as messages.
- These need to be checked continuously throughout the day with urgent tasks/messages being prioritized
- Make sure you are comfortable with the information in the task/message before calling patients as they almost always have questions
- Check their CPP and Chart before calling the patient to gather appropriate background information
- There are many resources around the office and online which can be helpful when conducting these phone calls
    - Its okay to tell the patient you don’t know an answer and will consult with the physician and follow up with them when you have an answer
- When relaying messages from the physician, if you are provided with specific details, relay the message as written where possible
    - When replying to the physician after you have spoken with the patient, write what you advised patient, their responses and indicate any follow ups, dates or additional information
    - Complete the task/message only when no further follow-up calls/messages are needed
    - Once tasks/messages are completed, they will no longer be visible to any of the users included on the task/messages
- If you need an urgent reply to a task/message, see the physician after sending the response through the EMR
- Document!
    - The goal is, if on any given day you are away, would another RN or the MRP be able to come in and pick up where you left off?
    - The more detail the better!

Preventative Screening

PAP Smears

- Start at age 21-25 if sexually active (oral and digital sex inclusive) and if not, delay until they are

- Patients will continue these until age 70 provided they have had 3 normal pap smears in the last 10 years. They may be discontinued sooner if the patient has had a total abdominal hysterectomy
    - Pap smears are repeated every 3 years if normal
    - If abnormal, you may be asked to call patients and advise about ASCUS and LSIL. There are some great resources online to help explain this to patients
    - For abnormal/normal pap smears
        - There are some cases where a patient with a normal pap may be interested in HPV testing. Check the guidelines for this request before offering
        - You can ask the doctor if HPV testing is needed for these abnormal pap smears. If they are, find the req for cytology, HPV and add to the bottom of the req that HPV testing is needed and ADD the date of the PAP collection (HPV can only be ordered within 30 days of the pap collection). There is a cost to the patient for this from the lab.
        - This requisition is faxed directly to LifeLabs Cytology and they will use the sample of PAP they already have to complete the HPV testing on (results will come back attached to the PAP results)

Colonoscopy/FIT

- These begin at age 50 unless the patient is high risk because of a family member with colon cancer, blood in stool or change in bowel habits
- These continue until age 74 of average risk
- For family history of colon cancer, colonoscopy starts 10 years before their family member's age of diagnosis if possible
- If high risk, expedite to colonoscopy, skip FIT
- If choosing FIT, normal screening is every 2 years
- If normal colonoscopy, screening is every 5-10 years (depending on family history, polyp findings, etc.). The GI will indicate in their note when next scope is due

Mammograms

- For high-risk patients with a family history of breast cancer, mammograms begin at age 30- they can be enrolled into the High Risk OBSP with a physician referral (see referral form for eligibility)
- Unless there is a family history or breast concerns, all patients are enrolled into OBSP as of the age of 50.
- Screening continues until age 74
- Mammograms are repeated between 1-2 years depending on risk status and findings

BMD

- High-risk patients may be seen sooner- this is clinically dependent

- Preventative screening typically begins at age 65 and then is repeated depending on outcome
- Those with low risk for fracture are repeated every 5 years
- Those with a moderate risk are repeated every 1-3 years
- Those high risk for fracture are usually checked yearly
- This timeline may vary and the best place to check for when they are next due would be within the report from the previous imaging

Quality Improvement Initiatives at the FHT

- The NYFHT has a few initiatives that require RN input: Falls, HbA1Cs, Stats
- You will get updates of your lists of patients who meet the criteria for each QI every quarter
    - Carve out time in your schedule to conduct these visits/calls. Refer to these lists and contact patients and document appropriately

Falls:

- Patients who are 75 and older with a diagnosis of osteoporosis/osteopenia are identified and sent as a list
- There is a Falls Screening form in the EMR to be completed (refer to QI cheat sheet). Pending results, patients may need in office assessments for TUGs
- Negative screening codes can be used in place of the screening template: “negative falls risk”
- Completing this screening tool will be sufficient to indicate that they should not be included in the next quarter’s QI list

HbA1Cs:

- The goal for this QI is to ensure that patients with diabetes have at least 2 HbA1Cs done per year
- The complication arises when patients do not need to be followed anymore OR if they are followed by an external specialist who orders these tests so they will not end up being flagged as done since we are not the prescriber
- We can check for external lab results using OLIS and if they have had 2 A1Cs within 12 months, a progress note needs to be entered into the chart saying “A1C, no FU”
- Otherwise, if they are due, speak with the MRP to order the requisition

Stats:

- After each visit, we are pseudo billing. This is to show the Ministry how the RNs’ time is being utilized and helps ensure we have appropriate staffing
- **Accuro:**
    - We create a new bill by hitting CTRL+B which will open a new bill. Click ENTER twice to bring up the most recent visit/patient you were documenting on
        - can also be done by right clicking on the patients’ name on the schedule and clicking on claims
    - Enter the RN codes

- For in-person visits, enter “RNPER” which will indicate they were seen in-person
- For longer telephone visits and telephone triages, enter “RNCAL” which will indicate this encounter was over the phone
- Next, enter the type of visit or call. Use multiple lines for more complex visits and calls that also included consults, forms, triages, ect.
    - This is done by pressing the “+” to add a new line under the RNPER or RNCAL. In that line, start with the code prefix “RN” and the code options will become visible. Choose the one that is most relevant to your visit. You will eventually get to know the codes off hand

- **PSS:**
    - With the patient’s chart open hit CTRL + shift + I to open a new custom form
    - Search “NYFHT stats” and select this
    - Click “RN” and click tick boxes that best represent the type of care provided

Tips and Tricks with Accuro/PSS

There a few tricks that we have found helpful with Accuro/PSS.

Basic Shortcuts:

Accuro:

F1- search a patient

F3- pull up patient’s virtual chart in a separate window (can close when done without exiting Accuro)

F4- booking history (shows when they were booked and by who and if the appointment was moved or edited and by who)

F12- your unique signature which should be used at the end of all documentation done by you

PSS: (if using a Mac, substitute “ctrl” with “apple key”

Ctrl + shift + M- opens messages

Ctrl + M- new message (if a patient chart is open, the new message will be attached to that patient)

Ctrl + alt + M- new instant message

From toolbar click “Patients” or from an open chart/”Records”, Ctrl + F – search a patient

Functions within a patient chart:

Ctrl + N- new progress note

Ctrl + I- insert stamp

Ctrl + shift + I- new custom form

Ctrl + B- prescribe

Ctrl + J- treatment/immunization

Ctrl + Alt + Shift + U to change supervising doctor, type the physician’s name or PSS initials. To remove supervision doctor click Ctrl + Alt + Shift + U and type “none”

Ctrl + 1-9 will display certain types of reports

- 1- all notes
- 2- only data I produced
- 3- notes containing… (search for any text in the patient chart)
- 4- only diagnostic imaging reports
- 5- only diagnostic test reports
- 6- only consult notes/reports
- 7- displays only notes that have been “selected” (green barred)
- 8- only labs. Ctrl + T will pull up lab table in a pop-up window
- 9- only treatments/vaccinations/prescriptions/allergies

Macros/Stamps

You can create your own macro/stamps which act as a guide to visits that you don’t want to forget details for (ie DMs, wound care, injections) but also help make documentation quicker

A power point can be emailed to you on how to create these Macros/Stamps, how to edit them and how to use them.

CDS/External Resources

This is an area where you can save frequently used links for quick access and reference in Accuro (CDS) or PSS (External Resources).

For Accuro Users:

To Add a New Link to Your CDS:

Go to the bullseye target→ CDS → Manage user CDS→ Green + → Name it and copy and paste the URL into the URL section → Click OK

To Access Saved Links:

Click the bullseye in the bottom left corner of the Accuro screen. Go to CDS. Saved CDSs will be below the black line (as will the CDS that come standard).

For PSS Users:

To Add a New Link to Your External Resources:

From the main toolbar **Help > External Resources > Manage Resources**.

This will open up a pop-up window to create the link.
From this pop up window click **Resources**.
At this point, you will have the option to create a public or private link. “Private” will create a link only visible to you. “Public” will create a link visible to all users on your server.
Fill in the **Title** and **URL** for the website (can free text or copy and paste) and click **Save** (bottom right).

To Access Saved Links:

You can access these links through the main toolbar **Help > External Resources** (all the links will be there in a drop-down menu). Click on the title of the link you wish to access.

EMR Functions:

How to create a lab requisition:

Bloodwork:

Accuro

a. That can be found on Accuro in the drawer and you can see it as “blank requisition for blood work”
b. Make sure you change the provider at the top to the ordering physician, select **REFRESH** (looks like two arrows in a circle). **CONFIRM** their name and signature are on the requisition.
c. If you cannot change the name at the top, the column over with the date needs to be dropped down and `none` needs to be selected. That will allow you to change the provider name
d. Have the physician review requisition before it is faxed/picked-up/mailed

PSS

- Ctrl + Alt + Shift + U to change supervising doctor (ordering physician)
- Ctrl + Shift + I to enter a new custom form. Search “2012 lab requisition” (the title of the requisition may vary from office to office)

Pap/Cytology

Accuro

- Open the Accuro Drawer on the chart and find req for cytology, pap, HPV

- enter the LMP and today's date, leave the req saved in the chart and the physician will update as needed
- ensure the correct ordering physician is on the requestion and is the MRP seeing that patient

PSS

- Ctrl + Alt + Shift + U to change supervising doctor (ordering physician)
- Ctrl + Shift + I to enter a new custom form. Search "Cytology and HPV Testing" (the title of the requisition may vary from office to office)

Faxing a Requisition:

Accuro

- Right click the req and select fax and then the + sign to find a number in the Address Book or the little man with the green + sign to free enter a number. Change the drop down to yourself and make sure cover sheet is selected

PSS

- Select the requisition and click Ctrl + Shift + F. Choose a letterhead person or use your own name.
- Enter text/the name of the recipient to search the address book (number of matches from the address book will be shown to the right) and click "OK" or press "tab" to view this list. Double click on addressee to select.
- If recipient is not saved in the address book, click "one-time address" to enter the information directly. Click "ok" when ready to fax.
- A pop-up window will come up to allow for any attachments to include in the fax i.e. CPP, notes previously selected/green barred, or lab table. Click "Fax" when ready to fax. Confirm fax details and click "Submit Fax Job" to complete fax.

DM Visit Documentation

Accuro

- Prior to visit, prep "Diabetes Flowsheet" found in the Accuro Drawer with labs, meds, immunizations (Tdap/Td, pneumo-23/Prevnar-13 (see above), Shingrix, flushot), foot check dates, eye check dates, last ECG and if followed by Endo/Nephro
- "select recent values" so that the flowsheet populates with all recent labs/vitals
- Click "add a comment" to document the visit
- Import the NYFHT Diabetes Macro to guide this visit (right click, find Macro, NYFHT_DM)

PSS

- Ctrl + Shift + I to open "Diabetes Visit" or "NYFHT Diabetes Visit and Flowsheet" custom form

- You may choose to insert the stamp titled “DMmacro” to help guide the visit by clicking Ctrl + I and search “DMmacro” or by clicking “Insert stamp ‘DMmacro’” on the “NYFHT Diabetes Visit and Flowsheet” custom form.

Creating NYFHT Referrals to Programs/Services:

Accuro

- Go to the drawer and search “NYFHT Referral Form”
- Select program or service
- For psychiatry and/or homebound referrals, these must be completed by a physician or in collaboration with a physician and with as much detail as possible
- Ask patient to call 707 Reception to initiate this appointment
- After the referral is saved in the chart, right click and send as a “task”
- Assign the task to NY Reception in 707 by changing the office location in the dropdown on the left-hand side of the task to 707-240DMR

PSS:

- Ctrl + Alt + Shift + U to change supervising doctor (ordering physician) if you are not the one referring
- Ctrl + Shift + I to enter a new custom form. Search “NYFHT referral form” and complete referral form
- Ensure any consult notes or lab results you wish to include in the referral are selected/green barred before faxing. Follow the steps above for “Faxing a Requisition”
- Ensure you click “Include profile” to include CPP with each referral when faxing

Helpful Links:

Here are some links you may find helpful:

Osteoporosis Canada
https://osteoporosis.ca/

Calcium Calculator through Osteoporosis Canada
https://osteoporosis.ca/bone-health-osteoporosis/calcium-calculator/#page-1

Diabetes Canada- Clinical Practice Guidelines
Diabetes Canada | Clinical Practice Guidelines - Full Guidelines

Diabetes Canada for Lipid targets and when to consider a statin
http://guidelines.diabetes.ca/reduce-complications/risk-assessment

Diabetes Canada for A1C targets
http://guidelines.diabetes.ca/reduce-complications/a1ctarget

OHIP Covered Physiotherapy clinics (MOHLTC)
http://www.health.gov.on.ca/en/public/programs/physio/pub_clinics.aspx

Dieticians of Canada
https://www.dietitians.ca/

Unlockfood
https://www.unlockfood.ca/en/default.aspx

Caring for Kids-Sick Kids
https://www.caringforkids.cps.ca/

Planned Parenthood Ontario Factsheet (different birth control methods and their uses, side effects etc) http://www.ppt.on.ca/resources/fact-sheets/

Sex & U (discussed contraception and pregnancy)
https://www.sexandu.ca/

Publicly Funded Vaccine Schedule Ontario
http://www.health.gov.on.ca/en/pro/programs/immunization/docs/immunization_schedule.pdf
https://www.health.gov.on.ca/en/pro/programs/immunization/docs/Publicly_Funded_ImmunizationSchedule.pdf

Canadian Immunization Guide: Part 4- Active Vaccines
https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines.html

2021 Canadian Cardiovascular Society Guidelines for the Management of Dyslipidemia for the Prevention of Cardiovascular Disease in Adults
https://www.onlinecjc.ca/article/S0828-282X(21)00165-3/fulltext

Cancer Care Ontario Screening Guidelines & Advice
https://www.cancercareontario.ca/en/guidelines-advice/cancer-continuum/screening/resources-healthcare-providers

OMAMA
https://www.omama.com/en/index.asp

CentralHealthLine
https://www.centralhealthline.ca/

Appendix E-

Role Descriptions.

Registered Practical Nurse

Reports to: Director, Programs and Services

Position status:

North York Family Health Team (NYFHT) provides accessible, person-focused, and family-centred primary health care through an interdisciplinary team committed to transforming health knowledge into best practices. We are committed to maintaining a culture of mutual respect, accountability, confidentiality, and collaboration. Working alongside the Department of Family & Community Medicine at North York General Hospital and the University of Toronto, we provide integrated, team-based primary care to over 90,000 individuals, and as a member of the North York Toronto Health Partners (NYTHP Ontario Health Team), are committed to improving the health and wellness of our community.

Our goal is to establish a community that is inclusive of all persons and treats everyone in an equitable manner. We are committed to equity and diversity in employment and encourage applications from all qualified candidates who reflect the diversity of our community, including but not limited to Indigenous peoples of North America, members of visible minorities, individuals identifying as 2SLGBTQ+, (dis)ability status, and/or others who may contribute to the further diversification of ideas. We seek to attract and retain individuals who will work together to create and sustain a vibrant, healthy, safe, and caring community.

The Registered Practical Nurse (RPN) will uphold the Mission and Vision of the North York Family Health Team and provide nursing services that are accessible, patient-centered, and utilize best practices to improve the health of the population. Specifically, the RPN will provide primary care to patients and families to promote, maintain and enhance patient's health and quality of life, while working alongside the interprofessional team including physicians, RNs, social workers, pharmacists, and others.

Responsibilities:

- Conduct history taking and physical assessments, consult and collaborate with physicians and allied health professionals, initiate, and implement interventions

and care plans, make referrals to NYFHT programs and services, and provide appropriate follow-up and evaluation.
- Perform basic nursing skills, measure vitals, administer immunization and medications/treatments prescribed by the doctor, provide injections, obtain electrocardiogram, apply dressings.
- Conduct preventative screening, chronic disease management, and health promotion activities based on clinical and best practice guidelines to positively impact health behaviours and outcomes.
- Order and maintain clinic supplies and equipment, and vaccine inventory.
- Establish and maintain therapeutic relationships by acting as a point of contact and care navigator for patients and families, as well as enhancing the patient experience.
- Provides care for patients throughout the lifespan i.e., perinatal, prenatal, infant, child/teen, and elder care.
- Acts as a resource to NYFHT members, as well as community and partner agencies.
- Supports the training of team members.
- Participates in and supports quality improvement initiatives, research, and program development in alignment with NYFHT's Strategic Plan
- Engages in continuous learning and professional development opportunities.
- Other duties as assigned.

Qualifications:

- Registered Practical Nurse license required.
- Current and in good standing certification as an RPN with the College of Nurses of Ontario (CNO).
- Preference given to those with at least 3 years experience in a primary health care setting and/or Emergency/Urgent Care
- Demonstrated computer literacy and experience with EMRs.
- Current CPR certification.
- Must have own vehicle and valid driver's license.

Skills:

- Ability to practice independently with proven organizational and prioritization skills.
- Demonstrated critical thinking and problem-solving skills.
- Excellent verbal and written communication skills
- Demonstrated interpersonal skills and ability working in interdisciplinary teams.

If interested, please apply to the attention of Human Resources by email: hr@nyfht.com. We thank all applicants for their interest, however, only those selected for an interview will be contacted.

Nurse Practitioner

Reports to: Director, Programs and Services

Position status:

North York Family Health Team (NYFHT) provides accessible, person-focused, and family-centered primary health care through an interdisciplinary team committed to transforming health knowledge into best practices. We are committed to maintaining a culture of mutual respect, accountability, confidentiality, and collaboration. Working alongside the Department of Family & Community Medicine at North York General Hospital and the University of Toronto, we provide integrated, team based primary care to over 90,000 individuals, and as a member of the North York Toronto Health Partners (NYTHP Ontario Health Team), are committed to improving the health and wellness of our community.

The North York Family Health Team's goal is to establish a community that is inclusive of all persons and treats everyone in an equitable manner. We are committed to equity and diversity in employment and encourage applications from all qualified candidates who reflect the diversity of our community, including but not limited to Indigenous peoples of North America, members of visible minorities, individuals identifying as 2SLGBTQ+, (dis)ability status, and/or others who may contribute to the further diversification of ideas. We seek to attract and retain individuals who will work together to create and sustain a vibrant, healthy, safe, and caring community.

Description

We are seeking a Nurse Practitioner who will work in partnership with the Medical Director, Physicians, and the interdisciplinary team to provide health care services focused on health promotion, prevention, and rehabilitation in accordance with the statutory and regulatory standards, limits and conditions, and employer policies and procedures. The Nurse Practitioner will work within the full scope of nursing practice as it pertains to family medicine and the scope of practice of a Nurse Practitioner as outlined in the CNO Standards of Practice for Registered Nurses in the Extended Class. This position may require frequent evening and weekend shifts based on the needs of the community and NYFHT programs and services.

As a Nurse Practitioner in good standing with the College of Nurses, you may be involved in:

- Leading an NP led community care program supporting patients of NYFHT physicians who are homebound by providing episodic care and follow up home visits.
- Developing and conducting a broad range of health promotion and chronic disease management processes, programs, and patient education, including the NYFHT Cancer Survivorship Program (CSP). Program training will be provided for the CSP.
- Leading, training, and organizing vaccine clinics and/or care clinic run by the NYFHT as the community requires.
- Providing direct patient care, including appropriate health prevention and wellness services
- Complete health assessments, including a health history and physical examination.
- Developing and documenting a plan of care for patients in collaboration with the multidisciplinary team
- Supporting and participating in the Community Health Information Fair
- As appropriate, share results of assessment and intervention with physicians, team members, hospital, home care and others in the circle of care.
- Ordering and interpreting diagnostic and laboratory tests
- Dispensing, prescribing, and administering medications or treatments
- In collaboration with the Physician and/or Pharmacist within the NP practice guidelines
- Participating in continuing education activities to integrate the role of the NP in primary care, academic settings, and case conferences.
- Promoting new ideas and innovations to expedite and improve the efficiencies for patient care in the primary care model.
- Participating in community needs assessment and program development.
- Other duties as assigned.

QUALIFICATIONS

- Advanced knowledge of the nursing process, program planning and development, research, and community resources
- Practical experience in primary healthcare, home care and/or oncology preferred.
- Handles first aid and medical issues as they arise in patient’s home.
- Demonstrated ability in problem solving using sound judgment and critical thinking.
- Current registration and in good standing with the College of Nurses of Ontario (as an Adult or Primary Health Care (Registered Nurse in the Extended Class)
- Minimum 2+ years relevant clinical and health assessment experience as a registered nurse in the extended class
- BScN and Master of Nursing required.
- Current (BCLS) certification required.
- Valid driver’s license (G class) and access to a personal vehicle for home visits
- Police Record/Vulnerable Sector Check

Skills

- Demonstrated computer literacy is required.
- Excellent interpersonal, verbal, and written communication skills
- Demonstrated critical thinking, problem-solving and organizational skills.
- Experience with electronic medical records (Accuro/PSS) an asset.
- Ability to work independently and cooperatively in a busy multidisciplinary team.

If interested, please apply to the attention of Human Resources by email: hr@nyfht.com. We thank all applicants for their interest, however, only those selected for an interview will be contacted.

Case Management

Reports to: Director, Programs and Services

Position status:

The Case Management role will uphold the mission and vision of the North York Family Health Team by providing patient-centered case management and system navigation service to patients and families. Will work closely with patients to assess and connect them with appropriate treatment options and resources.

Responsibilities:

- Provide advocacy, assessment, counselling, case management, support, and referral services to patients of the Family Health Team (NYFHT)
- Assist patients and families in navigating the health and social service systems by providing resources for to patients of NYFHT from different age groups, health, employment assistance, legal, income and housing support programs, medication funding, mental health supports, advance care planning, long term care planning and other community resources, as well as referral to appropriate NYFHT programs and services.
- Provide assessment, brief counselling, support, referral, and follow-up (pre and post treatment)
- Develop case plans based on client-centred goals.
- Develop and provide programs and workshops for patients and families/support persons.
- Present complex cases and disseminate information to the mental health team for peer support and learning.
- Collaborate and form partnerships with community agencies: including support programs.
- Build and manage a database on existing community resources.
- Strengthen knowledge base of interprofessional team and physicians by sharing information on community resources and local initiatives.
- Regular on-site presence within Physician office and clinic spaces
- Facilitate information sessions, resource updates and workshops for patients/families and internal/external providers on topics such as: maximizing income, advance care planning etc.

- Co-facilitate Social Worker group sessions based on Cognitive Behaviour Therapy (CBT) and Mindfulness therapy modalities as needed.
- Maintain timely and accurate documentation.
- Set targets, monitor, and evaluate strategies to achieve targets, and report outcomes.
- Complete other duties as assigned, identified through program needs.

Qualifications

Requirements

- Bachelor's degree in a health or social services field and registration in good standing with your college
- Minimum one-year experience working with the mental health sector.
- Minimum one-year experience in case management, preferably in a community health setting
- Strong Knowledge of community resources: preferably in the North York/GTA area.
- Strong knowledge of support services
- Strong skills in advocacy, needs assessment, supportive counselling, and group facilitation.
- Experience in the coordination of services, care planning, monitoring, and evaluation of ongoing care.
- Excellent interpersonal, verbal, and written communication skills
- Demonstrated critical thinking, problem-solving and organizational skills.
- Demonstrated ability to work independently and within a multidisciplinary team.
- Provide a Vulnerable Sector Screening (VSS) check from the Toronto Police Services.
- Must have own vehicle and a valid driver's license.

An Asset

- Knowledge of Post Traumatic Stress Disorder (PTSD) and training in trauma informed care and interventions are an asset.
- Demonstrated computer literacy where experience with Electronic Medical Records (Accuro/PSS) is an asset.
- Education/training in harm reduction, an asset.

If interested, please apply to the attention of Human Resources by email: hr@nyfht.com. We thank all applicants for their interest, however, only those selected for an interview will be contacted.

Social Worker

Reports to: Director, Programs and Services

Position status:

North York Family Health Team (NYFHT) provides accessible, person-focused, and family-centered primary health care through an interdisciplinary team committed to transforming health knowledge into best practices. We are committed to maintaining a culture of mutual respect, accountability, confidentiality, and collaboration. Working alongside the Department of Family & Community Medicine at North York General Hospital and the University of Toronto, we provide integrated, team based primary care to over 90,000 individuals, and as a member of the North York Toronto Health Partners (NYTHP Ontario Health Team), are committed to improving the health and wellness of our community.

The North York Family Health Team's goal is to establish a community that is inclusive of all persons and treats everyone in an equitable manner. We are committed to equity and diversity in employment and encourage applications from all qualified candidates who reflect the diversity of our community, including but not limited to Indigenous peoples of North America, members of visible minorities, individuals identifying as LGBTQ2S+, (dis)ability status, and/or others who may contribute to the further diversification of ideas. We seek to attract and retain individuals who will work together to create and sustain a vibrant, healthy, safe, and caring community.

The Social Worker will uphold the Mission and Vision of the North York Family Health Team by providing patient-centered services to patients and families within an interdisciplinary environment.

Description

We are seeking a Social Worker to work as part of our Mental Health team to provide a holistic and team-based approach to mental health care. We support individuals experiencing difficulty with various mental health challenges such as depression and anxiety. We offer the following short-term services: individual counseling, group programs, case management and psychiatric consultation.

As a social worker in good standing with the College of Social Workers, you will:

- Provide assessment, counseling/psychotherapy, support, and referral services to individuals/families with a broad range of mental and emotional health issues.
- Co-facilitate mental health group programs.
- Maintain accurate and up to date documentation.
- Contribute to case consultations/collaborations with mental health team and additional allied health team members as required.

QUALIFICATIONS:

- Master of Social Work degree from an accredited Social Work program required.
- Registered Social Worker (RSW) in good standing with the Ontario College of Social Workers and Social Service Workers (OCSWSSW)
- Previous experience working with mental health issues and current knowledge of accepted practices and legislation.
- 3-5 years of direct clinical experience including counseling, preferably in a community health setting
- Strong skills in advocacy, clinical assessment, individual/family counseling and treatment, and group facilitation
- Formal training and demonstrated knowledge of evidence-based treatment models including motivational interviewing, cognitive behavioral therapy, interpersonal psychotherapy, mindfulness-based approaches etc.
- Experience in the coordination of services, care planning, monitoring and evaluation of ongoing care.
- Knowledge and training in trauma informed care and interventions an asset
- Marital and/or family counseling an asset

Skills

- Excellent interpersonal, verbal, and written communication skills
- Demonstrated critical thinking, problem-solving and organizational skills.
- Demonstrated ability to work independently and within a multidisciplinary team.
- Demonstrated computer literacy.
- Experience with EMRs (Accuro/PSS) an asset

If interested, please apply to the attention of Human Resources by email: hr@nyfht.com. We thank all applicants for their interest, however, only those selected for an interview will be contacted.

Registered Dietitian

Reports to: Director, Programs and Services

Position status:

North York Family Health Team (NYFHT) provides accessible, person-focused, and family-centred primary health care through an interdisciplinary team committed to transforming health knowledge into best practices. We are committed to maintaining a culture of mutual respect, accountability, confidentiality, and collaboration. Working alongside the Department of Family & Community Medicine at North York General Hospital and the University of Toronto, we provide integrated, team-based primary care to over 90,000 individuals, and as a member of the North York Toronto Health Partners (NYTHP Ontario Health Team), are committed to improving the health and wellness of our community.

Our goal is to establish a community that is inclusive of all persons and treats everyone in an equitable manner. We are committed to equity and diversity in employment and encourage applications from all qualified candidates who reflect the diversity of our community, including but not limited to Indigenous peoples of North America, members of visible minorities, individuals identifying as 2SLGBTQ+, (dis)ability status, and/or others who may contribute to the further diversification of ideas. We seek to attract and retain individuals who will work together to create and sustain a vibrant, healthy, safe, and caring community.

The Registered Dietitian (RD) will uphold the Mission and Vision of the North York Family Health Team and provide specialized nutrition therapy in a primary care setting that is patient-centered and utilizes best practices to improve the health of the population. Specifically, the RD will provide primary care to patients and families to promote, maintain and enhance patient's health and quality of life, while working alongside the interprofessional team including physicians, RNs, social workers, pharmacists, and others.

Responsibilities:

- Lead and support various group sessions collaboration with physician consultants and the interdisciplinary team.
- Assess and record patient's nutritional status by conducting assessments utilizing information from the physician referral, patient history, lab reports and health record; implement interventions including education and counseling and provide monitoring and follow up.
- Identify priorities, and evidence-based strategies and interventions to create individualized nutrition treatment plans based on patient goals.
- Participate in professional development and educational activities, including providing clinical education to the multidisciplinary team, healthcare professionals and interns.

- Use of coaching methods or a coach-like approach with patients and team members
- Some evening hours may be required.
- Identify and/or participate in upcoming initiatives within the program.

Qualifications:

- Bachelor's degree in food and nutrition or equivalent degree with an accredited dietetic internship or equivalent supervised practical training required; post-graduate education preferred.
- A member in good standing with the College of Dietitians of Ontario.
- Demonstrated experience in assessing the nutritional status of patients, identifying concerns, developing care plans, and evaluating and monitoring the effectiveness of nutrition interventions for a variety of conditions such as: obesity, diabetes, dyslipidemia, inflammatory bowel disease, celiac, IBS, pre/post-natal nutrition, pediatric selective eating, malnutrition etc.
- Experience managing chronic diseases through nutrition interventions.
- Experience providing individual counseling and facilitating group education sessions.
- Demonstrated computer literacy is required to facilitate the use of electronic medical records.

Skills:

- Ability to work independently as well as collaboratively within a multidisciplinary team.
- Strong organizational, interpersonal and communication skills.
- Excellent verbal and written communication skills
- Ability to problem solve using sound judgment and critical thinking skills.
- Ability to work within a virtual environment and support patients within a hybrid model.

If interested, please apply to the attention of Human Resources by email: hr@nyfht.com. We thank all applicants for their interest, however, only those selected for an interview will be contacted.

Pharmacist

Reports to: Director, Programs and Services

Position status:

Collaborating with the multidisciplinary team, and using a patient-centered model of care, the Clinical Pharmacist will provide direct patient care, medication assessment, pharmacological consultation, pharmacotherapy monitoring, patient education and drug information.

Accountability:

As a Pharmacist, be accountable to the Ontario College of Pharmacists and must be credentialed per FHT policies and procedures

Duties and Responsibilities:

- Provides individual patient assessments to identify, prevent and resolve drug therapy problems
- Provides medication management in acute and chronic diseases including drug indications/contraindications, dosage and side effects drug interactions
- Provides evidence-based, timely and unbiased drug information
- Participates in multidisciplinary group patient education programs
- Participates in community needs assessment and program development
- Contributes to the development of chronic disease management, disease prevention and health promotion initiatives
- Teaches medical residents, pharmacy students, interns and residents and other allied health students as well as conducts pharmacy related educational seminars for the multidisciplinary team
- Contributes to the development and on-going refinement of the role of the Clinical Pharmacist in the NYFHT
- Assists with training and development of new staff
- Performs miscellaneous job-related duties as assigned.

Minimum Job Requirement:

- Part A license with the Ontario College of Pharmacists
- Bachelor's degree in Pharmacy, PharmD preferred

- Pharmacy practice residency preferred
- Minimum 3 years relevant clinical pharmacy experience
- Experience in a Family Health Team or primary care setting preferred
- Additional training or credentialing in pharmacotherapy (eg. Certified Respiratory/Asthma Educator, Certified Diabetes Educator, Certified Geriatric Pharmacist, Certified Tobacco Educator) preferred

Knowledge, Skills and Abilities Required:

- Experience working within a multidisciplinary team an asset
- Sound knowledge of chronic disease management and medication management
- Understanding of the pharmaceutical care process
- Strong ability in problem solving using sound judgment and critical thinking
- Experience in providing patient-centred care
- Ability to provide evidence-based unbiased drug information in a timely manner
- Computer literacy is required to facilitate the use of electronic medical records
- Strong organizational, interpersonal and communication skills
- Ability to work independently and cooperatively in a busy multidisciplinary team
- Appropriate oral and written communication skills to relay information to clinical and nonclinical personnel

Working Conditions:

- Work is normally performed in a typical interior/office work environment.
- General work schedule is Monday to Friday day time hours; some evenings and weekends required.
- The North York Family Health Team (NYFHT) offers a competitive salary and benefits package.

If interested, please apply to the attention of Human Resources by email to hr@nyfht.com

The North York Family Health Team is committed to equity in employment and encourages applications from all qualified candidates who reflect the diversity of our community, including men and women, aboriginal peoples, members of visible minorities and persons with disabilities.

We seek to attract and retain individuals who will work together to create and sustain a vibrant, healthy, safe and caring community. While all responses will be appreciated and handled in strictest confidence, only those being considered for interviews will be acknowledged.

Canadian Mental Health Association Toronto

CANADIAN MENTAL HEALTH ASSOCIATION
TORONTO BRANCH

POSITION DESCRIPTION

Title: **Nurse Practitioner**
Reporting to: Manager, Primary Health Care and ACT Stepped Care Transition Team
Program: ACT Stepped Care

Position Summary:

- The Nurse Practitioner (NP) works collaboratively with the client and the ACT Stepped Care Transition Team to assess, plan, develop, coordinate and provide treatment, rehabilitation and support. The NP is responsible for conducting comprehensive psychiatric history and assessment, assessing physical health needs, formulate and communicate a diagnosis, prescribe all medications including controlled drugs and substances, order and interpret all laboratory tests, order some diagnostic imaging tests, provide management and administration of medication in responsibility with other team members, and making referrals to community physicians and other health care services. The NP will participate in program development and in policy-making activities that influence health services and practices in the ACTT Stepped Care program. The NP will engage teams/community in implanting change, while building collaborative relationships with Staff and ACT Stepped Care clients.

Principal Responsibilities:

1. Intake assessment

- Actively participates in intake interviews to determine suitability for ACT Stepped Care Program at CMHA Toronto and Scarborough Health Network
- Ensure limits of confidentiality are discussed with clients
- Conducts comprehensive client assessment multidisciplinary assessments to understand the client's needs
- Complete a comprehensive health history and assessment:
- Provides comprehensive primary health care including assessments, diagnoses, counselling, screening, referral, education, treatment and follow- up
- Works with patient to determine presence of existing and potential health problems
- Involves patient and families in identifying risk factors and health problems, goal setting and interventions for disease, treatment, prevention and health promotion
- Determines the need for, and orders, laboratory and diagnostic tests, x-rays and ultrasounds; interprets results and collaborates with primary health care provider.
- Keeps records of patient interactions to assist other practitioners in continuing patient care and collect statistical information
- Collaborates with providers and patients to ensure care, management, referrals and information

2. Service Care/Treatment Planning:

- Ensures evidence based/best practices guide treatment and interventions.
- Order and interpret all laboratory tests
- Formulate and document a plan of care based on assessment findings, diagnosis and evidence informed practice.
- Select the appropriate treatments or interventions in collaboration with the client.
- Perform appropriate procedures
- Works with patient to determine presence of existing and potential health problems
- Involves patient and families in identifying risk factors and health problems, goal setting and interventions for disease, treatment, prevention and health promotion
- Collaborates with providers and patients to ensure care, management, referrals and information.
- Interprets results and consults/collaborates with Primary Care provider
- Provides ongoing care and next steps
- Perform medication reconciliation as appropriate
- Consult with the ACTT Psychiatrists in cases deemed appropriate
- Review consultation and/or referral recommendations from other health care providers with the client and integrate these recommendations into the plan of care as appropriate.

3. Health Promotion:

- Provides in-depth health promotion education and preventive health teaching regarding psychosis and related issues to staff, clients, family, and community partners
- Assists the client to access primary health care services.
- Administers prescribed medication, monitor its effectiveness and assess client adherence with treatment.
- Collaborates with client and other ACT Stepped Care resources to assist the client to maintain an effective medication regimen.
- Educates the client, ACT Stepped Care team and relevant others about medication and side effects and assist the client to cope with medication side effects.
- Assists the client to identify and cope with those symptoms that interfere with daily functioning.
- Provides developmentally appropriate counselling including issues of identity, sexuality and relationships

4. Linking with Community Resources:

- Establishes effective working relationship with staff of other agencies.
- Teaches the client to negotiate services with greater effectiveness.
- Liaise with external stakeholders to bridge transition to community setting for continuation of psychiatric and primary health client care
- Participate in clinical team meetings and CCP (Coordinated Care Plans)
- Consult other health care professionals when encountering client care needs or when the client would benefit from the expertise of the other health care professional(s).

5. Crisis Prevention/Intervention:

- Assess the significance of changes in the client's clinical status and intervene before a crisis escalates
- Provide crisis intervention and support
- Facilitate psychiatric and medical intervention as appropriate
- Provide follow-up once the crisis has been stabilized

6. Family Education and Support:

- Educate the family and substitute decision maker on the nature of the illness, treatment, medication and community integration.
- Provides culturally appropriate resources and support to help families and substitute decision maker cope more effectively.

7. Advocacy:

- Advocate on behalf of the client as necessary.
- The NP presents the services of CMHA Metro Toronto in a professional manner.
- Support integration between primary care and mental health services

8. Discharge Planning:

- Participate in the development of a discharge plan in collaboration with the client, ACT Stepped Care Team and relevant others. According to program guidelines
- Ensure that continuity of care is provided where necessary

9. Administration:

- Maintains relevant documentation of mediation orders and medication administration in accordance with the College of Nurses of Ontario
- Maintain active membership with the College of Nurses of Ontario
- Completes timesheets, record keeping (i.e. Kardex, biopsychosocial, daily notes and assessments) within set timelines.

Education:

- Nurse Practitioner Degree/Canadian Psychiatric Mental Health Nursing
- Current registration with the College of Nurses of Ontario and RNAO or NPAO CPMHN(c)

CMHA is a Health Information Custodian and as such it is a requirement to adhere to the personal Health Information protection Act (PHIPA) and all other CMHA privacy policy and procedures. See Section 4 of the Policy and Procedures manual for further detail.

It is the responsibility of each staff member to adhere to CMHA Policies and Procedures. It is also the responsibility of each staff member to report client and worker safety concerns and to communicate with the Occupational Health and Safety Committee and management to create a safe working environment at CMHA.

Disclaimer

This job description indicates the general nature and level of work expected. It is not designed to cover or contain a comprehensive listing of activities, duties or responsibilities required by the incumbent. Incumbent may be asked to perform other duties as required.

Employee Signature	**Date (MM/DD/YYYY)**
Program Director Signature	**Date (MM/DD/YYYY)**

Canadian Mental Health Association Toronto

CANADIAN MENTAL HEALTH ASSOCIATION
TORONTO BRANCH

POSITION DESCRIPTION

Title: **Registered Nurse Case Manager**
Reporting to: Manager, Primary Health Care and ACT Stepped Care Transition Team
Program: ACT Stepped Care

Position Summary:

- The Registered Nurse (RN) works collaboratively with the client and the ACT Stepped Care Transition Team to assess, develop individualized treatment plan, develop, coordinate and provide treatment, rehabilitation and support to clients in their journey of receovery. The RN is responsible for conducting psychiatric assessment, assessing physical health needs, assessing environment, making referrals to community physicians and providing management and administration of medication in responsibility with other team members. The RN provides guidance to other team members for individuals with complex care needs. The RN will also provide case management services.

Principal Responsibilities:

1. **Intake assessment**

   - Actively participates in intake interviews to determine suitability for ACT Stepped Care Program
   - Ensure limits of confidentiality are discussed with clients
   - Conducts comprehensive client assessment multidisciplinary assessments to understand the client's needs
   - The RN will conduct psychiatric and physical health assessments.

2. **Service Care Planning:**

   - Develops an individual recovery oriented service plan with the client, which incorporates the client's goals, values, skills, resources, strengths and service requirements.
   - Ensures evidence based/best practices guide treatment and interventions.
   - Ensures client's linguistic and cultural needs are considered in the service plans.

3. **Health Promotion:**

   - Provides in-depth health promotion education and preventive health teaching regarding psychosis and related issues.
   - Assists the client to access primary health care services.
   - Administers prescribed medication, monitor its effectiveness and assess client adherence with treatment.

- Collaborates with client and other ACT Stepped Care resources to assist the client to maintain an effective medication regimen.
- Educates the client, ACT Stepped Care team and relevant others about medication and side effects and assist the client to cope with medication side effects.
- Assists the client to identify and cope with those symptoms that interfere with daily functioning.
- Provides developmentally appropriate counselling including issues of identity, sexuality and relationships

4. Development of Independent Living Skills:

- Teaches a range of living skills including: personal hygiene, cooking, nutrition, shopping, money management, transportation and household management.
- Assesses the client's employment wishes and capabilities through vocational exploration.
- Assists clients to access, explore and develop employment opportunities.
- Assists clients to develop good work ethics and habits
- Assists the client to develop social skills.
- Links client to social/recreational activities based on the client's needs and interests.
- Initiate referrals to other community services as required

5. Linking with Community Resources:

- Establishes effective working relationship with staff of other agencies.
- Teaches the client to negotiate services with greater effectiveness.
- Assist clients to access, explore and develop employment opportunities.
- Work along with the client, assisting him/her to develop good work ethics and habits
- Prepare both the agency staff as well as the client for what they can expect from each other
- Accompany the client to the new agency

6. Social Skills Teaching, Socialization and Recreational Activities:

- Assist the client to develop social skills.
- Establishes effective working relationship with staff of other agencies.
- Develop, organize and implement social/recreational activities based on the client's needs and interests.
- Provide supportive counselling to facilitate problem solving

7. Crisis Prevention/Intervention:

- In collaboration with the client, ACT Stepped Care Team and relevant others, develop a crisis plan.
- Assess the significance of changes in the client's clinical status and intervene before a crisis escalates
- Provide crisis intervention and support
- Facilitate psychiatric and medical intervention as appropriate
- Provide follow-up once the crisis has been stablilized

8. Family Education and Support:

- Educate the family and substitute decision maker on the nature of the illness, treatment, medication and community integration.
- Provides culturally appropriate resources and support to help families and substitute decision maker cope more effectively.

9. Crisis Prevention/Intervention:

- In collaboration with the client, ACT Stepped Care Team and relevant others, develop a crisis plan.
- Assess the significance of changes in the client's clinical status and intervene before a crisis escalates.
- Facilitate psychiatric and medical intervention as appropriate.
- Provide follow up once the crisis has been stabilized.

10. Advocacy:

- Advocate on behalf of the client as necessary.
- The RN/RPN presents the services of CMHA Metro Toronto in a professional manner.

11. Discharge Planning:

- Participate in the development of a discharge plan in collaboration with the client, ACT Stepped Care Team and relevant others. According to program guidelines
- Ensure that continuity of care is provided where necessary

12. Administration:

- Maintains relevant documentation of mediation orders and medication administration in accordance with the College of Nurses of Ontario
- Maintain active membership with the College of Nurses of Ontario
- Completes timesheets, record keeping (i.e. Kardex, biopsychosocial, daily notes and assessments) within set timelines.

Job Specifications

Experience:

- Knowledge and skill in the assessment and treatment of people with mental health issues and disorders.
- Skills and knowledge to administer and score mental health related test instruments appropriate to the profession.
- Knowledge and skill to conduct bio-psycho-social assessments including mental status exams.
- Advanced knowledge of psychotropic medications as prescribed by a physician, and the effects of such medications.
- Skills and knowledge of psychotropic medication and how to administer medications as required.
- Experience in providing counselling to clients around issues related to medications and there effects
- Experience providing a consultant/educative service from a nursing perspective to other service providers and other community agency staff.
- Knowledge of the recovery approach in mental health
- Minimum of 2 years experience in mental health

Education:

- Degree in nursing
- Registration with the Ontario College of Nurses

CMHA is a Health Information Custodian and as such it is a requirement to adhere to the personal Health Information protection Act (PHIPA) and all other CMHA privacy policy and procedures. See Section 4 of the Policy and Procedures manual for further detail.

It is the responsibility of each staff member to adhere to CMHA Policies and Procedures. It is also the responsibility of each staff member to report client and worker safety concerns and to communicate with the Occupational Health and Safety Committee and management to create a safe working environment at CMHA.

Disclaimer

This job description indicates the general nature and level of work expected. It is not designed to cover or contain a comprehensive listing of activities, duties or responsibilities required by the incumbent. Incumbent may be asked to perform other duties as required.

_____	_____
Employee Signature	**Date (MM/DD/YYYY)**
_____	_____
Program Director Signature	**Date (MM/DD/YYYY)**

Canadian Mental Health Association Toronto

CANADIAN MENTAL HEALTH ASSOCIATION
TORONTO BRANCH

POSITION DESCRIPTION

Title: **Nurse Practitioner**
Reporting to: Manager, Primary Health Care and ACT Stepped Care Transition Team
Program: ACT Stepped Care

Position Summary:

- The Nurse Practitioner (NP) works collaboratively with the client and the ACT Stepped Care Transition Team to assess, plan, develop, coordinate and provide treatment, rehabilitation and support. The NP is responsible for conducting comprehensive psychiatric history and assessment, assessing physical health needs, formulate and communicate a diagnosis, prescribe all medications including controlled drugs and substances, order and interpret all laboratory tests, order some diagnostic imaging tests, provide management and administration of medication in responsibility with other team members, and making referrals to community physicians and other health care services. The NP will participate in program development and in policy-making activities that influence health services and practices in the ACTT Stepped Care program. The NP will engage teams/community in implanting change, while building collaborative relationships with Staff and ACT Stepped Care clients.

Principal Responsibilities:

1. Intake assessment

- Actively participates in intake interviews to determine suitability for ACT Stepped Care Program at CMHA Toronto and Scarborough Health Network
- Ensure limits of confidentiality are discussed with clients
- Conducts comprehensive client assessment multidisciplinary assessments to understand the client's needs
- Complete a comprehensive health history and assessment:
- Provides comprehensive primary health care including assessments, diagnoses, counselling, screening, referral, education, treatment and follow- up
- Works with patient to determine presence of existing and potential health problems
- Involves patient and families in identifying risk factors and health problems, goal setting and interventions for disease, treatment, prevention and health promotion
- Determines the need for, and orders, laboratory and diagnostic tests, x-rays and ultrasounds; interprets results and collaborates with primary health care provider.
- Keeps records of patient interactions to assist other practitioners in continuing patient care and collect statistical information
- Collaborates with providers and patients to ensure care, management, referrals and information

2. Service Care/Treatment Planning:

- Ensures evidence based/best practices guide treatment and interventions.
- Order and interpret all laboratory tests
- Formulate and document a plan of care based on assessment findings, diagnosis and evidence informed practice.
- Select the appropriate treatments or interventions in collaboration with the client.
- Perform appropriate procedures
- Works with patient to determine presence of existing and potential health problems
- Involves patient and families in identifying risk factors and health problems, goal setting and interventions for disease, treatment, prevention and health promotion
- Collaborates with providers and patients to ensure care, management, referrals and information.
- Interprets results and consults/collaborates with Primary Care provider
- Provides ongoing care and next steps
- Perform medication reconciliation as appropriate
- Consult with the ACTT Psychiatrists in cases deemed appropriate
- Review consultation and/or referral recommendations from other health care providers with the client and integrate these recommendations into the plan of care as appropriate.

3. Health Promotion:

- Provides in-depth health promotion education and preventive health teaching regarding psychosis and related issues to staff, clients, family, and community partners
- Assists the client to access primary health care services.
- Administers prescribed medication, monitor its effectiveness and assess client adherence with treatment.
- Collaborates with client and other ACT Stepped Care resources to assist the client to maintain an effective medication regimen.
- Educates the client, ACT Stepped Care team and relevant others about medication and side effects and assist the client to cope with medication side effects.
- Assists the client to identify and cope with those symptoms that interfere with daily functioning.
- Provides developmentally appropriate counselling including issues of identity, sexuality and relationships

4. Linking with Community Resources:

- Establishes effective working relationship with staff of other agencies.
- Teaches the client to negotiate services with greater effectiveness.
- Liaise with external stakeholders to bridge transition to community setting for continuation of psychiatric and primary health client care
- Participate in clinical team meetings and CCP (Coordinated Care Plans)
- Consult other health care professionals when encountering client care needs or when the client would benefit from the expertise of the other health care professional(s).

5. Crisis Prevention/Intervention:

- Assess the significance of changes in the client's clinical status and intervene before a crisis escalates
- Provide crisis intervention and support
- Facilitate psychiatric and medical intervention as appropriate
- Provide follow-up once the crisis has been stabilized

6. Family Education and Support:

- Educate the family and substitute decision maker on the nature of the illness, treatment, medication and community integration.
- Provides culturally appropriate resources and support to help families and substitute decision maker cope more effectively.

7. Advocacy:

- Advocate on behalf of the client as necessary.
- The NP presents the services of CMHA Metro Toronto in a professional manner.
- Support integration between primary care and mental health services

8. Discharge Planning:

- Participate in the development of a discharge plan in collaboration with the client, ACT Stepped Care Team and relevant others. According to program guidelines
- Ensure that continuity of care is provided where necessary

9. Administration:

- Maintains relevant documentation of mediation orders and medication administration in accordance with the College of Nurses of Ontario
- Maintain active membership with the College of Nurses of Ontario
- Completes timesheets, record keeping (i.e. Kardex, biopsychosocial, daily notes and assessments) within set timelines.

Education:

- Nurse Practitioner Degree/Canadian Psychiatric Mental Health Nursing
- Current registration with the College of Nurses of Ontario and RNAO or NPAO CPMHN(c)

CMHA is a Health Information Custodian and as such it is a requirement to adhere to the personal Health Information protection Act (PHIPA) and all other CMHA privacy policy and procedures. See Section 4 of the Policy and Procedures manual for further detail.

It is the responsibility of each staff member to adhere to CMHA Policies and Procedures. It is also the responsibility of each staff member to report client and worker safety concerns and to communicate with the Occupational Health and Safety Committee and management to create a safe working environment at CMHA.

Disclaimer

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Employee Signature	**Date (MM/DD/YYYY)**
Program Director Signature	**Date (MM/DD/YYYY)**

Canadian Mental Health Association Toronto

REGISTERED PRACTICAL NURSE (RPN), CASE MANAGER

PRIMARY HEALTH CARE: NP STEPPED CARE PROGRAM – WEST

(Full Time, Permanent)

The Canadian Mental Health Association Toronto Branch is a non-profit community based mental health agency providing a wide range of services across Toronto.

The Primary Health Care Team, has an opening for a Registered Practical Nurse (RPN). The RPN will take on a vital role in bridging the transition of ACTT Stepped Care clients out of ACTT services and into the primary health care setting in the community. Contact with clients and families are provided in office and in the community. The RPN will work closely with the Mental Health Nurse Practitioner to provide community based support, rehabilitation, and treatment for people living with mental illness. A strong focus on stabilization, community integration, quality of life and recovery from mental illness. The RPN will report to the Manager of Primary Health Care.

Key Responsibilities:
As part of the team you will:

- Develop therapeutic alliance with clients and their support systems/significant others
- Provide psycho-education around meds and symptoms
- Monitor treatment regimes
- Assess mental status and monitor physical health needs
- Support the agency's primary health care and chronic disease management initiative
- Assess client needs and link to appropriate resources
- Work from a recovery based perspective
- Collaborate service provision with other team members

The position requires the following:

- Current certification with the College of Nurses of Ontario as a Registered Practical Nurse
- Current personal liability insurance protection with RPNAO or equivalent provider
- 2 years experience working with people with mental illness, preferably community-based
- Excellent skills in mental health assessment and teaching, medication monitoring, case management, and crisis intervention
- Excellent organizational skills are required
- Ability to work independently and in a dynamic team environment
- Knowledge and understanding of the ACT Model and recovery-oriented practice
- Experience with addictions, forensics and dual diagnosis is an asset
- Fluency in a second language is an asset
- Ability to work with diverse communities
- Ability to work from an anti-oppressive framework

Successful applicants must have a valid Ontario driver's license, access to a vehicle and insurance for transporting clients.

The Canadian Mental Health Association is an equal opportunity employer and encourages applications from equity seeking groups including qualified individuals with personal experience of the mental health system. If you are contact by our offices regarding a job opportunity please advise prior to the interview should you require any accommodation

Canadian Mental Health Association Toronto

CANADIAN MENTAL HEALTH ASSOCIATION
TORONTO BRANCH

POSITION DESCRIPTION

Title: **Nurse Practitioner**
Reporting to: Manager, Primary Health Care and ACT Stepped Care Transition Team
Program: ACT Stepped Care

Position Summary:

- The Nurse Practitioner (NP) works collaboratively with the client and the ACT Stepped Care Transition Team to assess, plan, develop, coordinate and provide treatment, rehabilitation and support. The NP is responsible for conducting comprehensive psychiatric history and assessment, assessing physical health needs, formulate and communicate a diagnosis, prescribe all medications including controlled drugs and substances, order and interpret all laboratory tests, order some diagnostic imaging tests, provide management and administration of medication in responsibility with other team members, and making referrals to community physicians and other health care services. The NP will participate in program development and in policy-making activities that influence health services and practices in the ACTT Stepped Care program. The NP will engage teams/community in implanting change, while building collaborative relationships with Staff and ACT Stepped Care clients.

Principal Responsibilities:

1. Intake assessment

- Actively participates in intake interviews to determine suitability for ACT Stepped Care Program at CMHA Toronto and Scarborough Health Network
- Ensure limits of confidentiality are discussed with clients
- Conducts comprehensive client assessment multidisciplinary assessments to understand the client's needs
- Complete a comprehensive health history and assessment:
- Provides comprehensive primary health care including assessments, diagnoses, counselling, screening, referral, education, treatment and follow- up
- Works with patient to determine presence of existing and potential health problems
- Involves patient and families in identifying risk factors and health problems, goal setting and interventions for disease, treatment, prevention and health promotion
- Determines the need for, and orders, laboratory and diagnostic tests, x-rays and ultrasounds; interprets results and collaborates with primary health care provider.
- Keeps records of patient interactions to assist other practitioners in continuing patient care and collect statistical information
- Collaborates with providers and patients to ensure care, management, referrals and information

2. Service Care/Treatment Planning:

- Ensures evidence based/best practices guide treatment and interventions.
- Order and interpret all laboratory tests
- Formulate and document a plan of care based on assessment findings, diagnosis and evidence informed practice.
- Select the appropriate treatments or interventions in collaboration with the client.
- Perform appropriate procedures
- Works with patient to determine presence of existing and potential health problems
- Involves patient and families in identifying risk factors and health problems, goal setting and interventions for disease, treatment, prevention and health promotion
- Collaborates with providers and patients to ensure care, management, referrals and information.
- Interprets results and consults/collaborates with Primary Care provider
- Provides ongoing care and next steps
- Perform medication reconciliation as appropriate
- Consult with the ACTT Psychiatrists in cases deemed appropriate
- Review consultation and/or referral recommendations from other health care providers with the client and integrate these recommendations into the plan of care as appropriate.

3. Health Promotion:

- Provides in-depth health promotion education and preventive health teaching regarding psychosis and related issues to staff, clients, family, and community partners
- Assists the client to access primary health care services.
- Administers prescribed medication, monitor its effectiveness and assess client adherence with treatment.
- Collaborates with client and other ACT Stepped Care resources to assist the client to maintain an effective medication regimen.
- Educates the client, ACT Stepped Care team and relevant others about medication and side effects and assist the client to cope with medication side effects.
- Assists the client to identify and cope with those symptoms that interfere with daily functioning.
- Provides developmentally appropriate counselling including issues of identity, sexuality and relationships

4. Linking with Community Resources:

- Establishes effective working relationship with staff of other agencies.
- Teaches the client to negotiate services with greater effectiveness.
- Liaise with external stakeholders to bridge transition to community setting for continuation of psychiatric and primary health client care
- Participate in clinical team meetings and CCP (Coordinated Care Plans)
- Consult other health care professionals when encountering client care needs or when the client would benefit from the expertise of the other health care professional(s).

5. Crisis Prevention/Intervention:

- Assess the significance of changes in the client's clinical status and intervene before a crisis escalates
- Provide crisis intervention and support
- Facilitate psychiatric and medical intervention as appropriate
- Provide follow-up once the crisis has been stabilized

6. Family Education and Support:

- Educate the family and substitute decision maker on the nature of the illness, treatment, medication and community integration.
- Provides culturally appropriate resources and support to help families and substitute decision maker cope more effectively.

7. Advocacy:

- Advocate on behalf of the client as necessary.
- The NP presents the services of CMHA Metro Toronto in a professional manner.
- Support integration between primary care and mental health services

8. Discharge Planning:

- Participate in the development of a discharge plan in collaboration with the client, ACT Stepped Care Team and relevant others. According to program guidelines
- Ensure that continuity of care is provided where necessary

9. Administration:

- Maintains relevant documentation of mediation orders and medication administration in accordance with the College of Nurses of Ontario
- Maintain active membership with the College of Nurses of Ontario
- Completes timesheets, record keeping (i.e. Kardex, biopsychosocial, daily notes and assessments) within set timelines.

Education:

- Nurse Practitioner Degree/Canadian Psychiatric Mental Health Nursing
- Current registration with the College of Nurses of Ontario and RNAO or NPAO CPMHN(c)

CMHA is a Health Information Custodian and as such it is a requirement to adhere to the personal Health Information protection Act (PHIPA) and all other CMHA privacy policy and procedures. See Section 4 of the Policy and Procedures manual for further detail.

It is the responsibility of each staff member to adhere to CMHA Policies and Procedures. It is also the responsibility of each staff member to report client and worker safety concerns and to communicate with the Occupational Health and Safety Committee and management to create a safe working environment at CMHA.

Disclaimer

This job description indicates the general nature and level of work expected. It is not designed to cover or contain a comprehensive listing of activities, duties or responsibilities required by the incumbent. Incumbent may be asked to perform other duties as required.

Employee Signature	**Date (MM/DD/YYYY)**
Program Director Signature	**Date (MM/DD/YYYY)**

Canadian Mental Health Association Toronto

CANADIAN MENTAL HEALTH ASSOCIATION
TORONTO BRANCH

POSITION DESCRIPTION

Title: **Registered Nurse Case Manager**
Reporting to: Manager, Primary Health Care and ACT Stepped Care Transition Team
Program: ACT Stepped Care

Position Summary:

- The Registered Nurse (RN) works collaboratively with the client and the ACT Stepped Care Transition Team to assess, develop individualized treatment plan, develop, coordinate and provide treatment, rehabilitation and support to clients in their journey of receovery. The RN is responsible for conducting psychiatric assessment, assessing physical health needs, assessing environment, making referrals to community physicians and providing management and administration of medication in responsibility with other team members. The RN provides guidance to other team members for individuals with complex care needs. The RN will also provide case management services.

Principal Responsibilities:

1. **Intake assessment**

   - Actively participates in intake interviews to determine suitability for ACT Stepped Care Program
   - Ensure limits of confidentiality are discussed with clients
   - Conducts comprehensive client assessment multidisciplinary assessments to understand the client's needs
   - The RN will conduct psychiatric and physical health assessments.

2. **Service Care Planning:**

   - Develops an individual recovery oriented service plan with the client, which incorporates the client's goals, values, skills, resources, strengths and service requirements.
   - Ensures evidence based/best practices guide treatment and interventions.
   - Ensures client's linguistic and cultural needs are considered in the service plans.

3. **Health Promotion:**

   - Provides in-depth health promotion education and preventive health teaching regarding psychosis and related issues.
   - Assists the client to access primary health care services.
   - Administers prescribed medication, monitor its effectiveness and assess client adherence with treatment.

- Collaborates with client and other ACT Stepped Care resources to assist the client to maintain an effective medication regimen.
- Educates the client, ACT Stepped Care team and relevant others about medication and side effects and assist the client to cope with medication side effects.
- Assists the client to identify and cope with those symptoms that interfere with daily functioning.
- Provides developmentally appropriate counselling including issues of identity, sexuality and relationships

4. Development of Independent Living Skills:

- Teaches a range of living skills including: personal hygiene, cooking, nutrition, shopping, money management, transportation and household management.
- Assesses the client's employment wishes and capabilities through vocational exploration.
- Assists clients to access, explore and develop employment opportunities.
- Assists clients to develop good work ethics and habits
- Assists the client to develop social skills.
- Links client to social/recreational activities based on the client's needs and interests.
- Initiate referrals to other community services as required

5. Linking with Community Resources:

- Establishes effective working relationship with staff of other agencies.
- Teaches the client to negotiate services with greater effectiveness.
- Assist clients to access, explore and develop employment opportunities.
- Work along with the client, assisting him/her to develop good work ethics and habits
- Prepare both the agency staff as well as the client for what they can expect from each other
- Accompany the client to the new agency

6. Social Skills Teaching, Socialization and Recreational Activities:

- Assist the client to develop social skills.
- Establishes effective working relationship with staff of other agencies.
- Develop, organize and implement social/recreational activities based on the client's needs and interests.
- Provide supportive counselling to facilitate problem solving

7. Crisis Prevention/Intervention:

- In collaboration with the client, ACT Stepped Care Team and relevant others, develop a crisis plan.
- Assess the significance of changes in the client's clinical status and intervene before a crisis escalates
- Provide crisis intervention and support
- Facilitate psychiatric and medical intervention as appropriate
- Provide follow-up once the crisis has been stablilized

8. Family Education and Support:

- Educate the family and substitute decision maker on the nature of the illness, treatment, medication and community integration.
- Provides culturally appropriate resources and support to help families and substitute decision maker cope more effectively.

9. Crisis Prevention/Intervention:

- In collaboration with the client, ACT Stepped Care Team and relevant others, develop a crisis plan.
- Assess the significance of changes in the client's clinical status and intervene before a crisis escalates.
- Facilitate psychiatric and medical intervention as appropriate.
- Provide follow up once the crisis has been stabilized.

10. Advocacy:

- Advocate on behalf of the client as necessary.
- The RN/RPN presents the services of CMHA Metro Toronto in a professional manner.

11. Discharge Planning:

- Participate in the development of a discharge plan in collaboration with the client, ACT Stepped Care Team and relevant others. According to program guidelines
- Ensure that continuity of care is provided where necessary

12. Administration:

- Maintains relevant documentation of mediation orders and medication administration in accordance with the College of Nurses of Ontario
- Maintain active membership with the College of Nurses of Ontario
- Completes timesheets, record keeping (i.e. Kardex, biopsychosocial, daily notes and assessments) within set timelines.

Job Specifications

Experience:

- Knowledge and skill in the assessment and treatment of people with mental health issues and disorders.
- Skills and knowledge to administer and score mental health related test instruments appropriate to the profession.
- Knowledge and skill to conduct bio-psycho-social assessments including mental status exams.
- Advanced knowledge of psychotropic medications as prescribed by a physician, and the effects of such medications.
- Skills and knowledge of psychotropic medication and how to administer medications as required.
- Experience in providing counselling to clients around issues related to medications and there effects
- Experience providing a consultant/educative service from a nursing perspective to other service providers and other community agency staff.
- Knowledge of the recovery approach in mental health
- Minimum of 2 years experience in mental health

Education:

- Degree in nursing
- Registration with the Ontario College of Nurses

CMHA is a Health Information Custodian and as such it is a requirement to adhere to the personal Health Information protection Act (PHIPA) and all other CMHA privacy policy and procedures. See Section 4 of the Policy and Procedures manual for further detail.

It is the responsibility of each staff member to adhere to CMHA Policies and Procedures. It is also the responsibility of each staff member to report client and worker safety concerns and to communicate with the Occupational Health and Safety Committee and management to create a safe working environment at CMHA.

Disclaimer

This job description indicates the general nature and level of work expected. It is not designed to cover or contain a comprehensive listing of activities, duties or responsibilities required by the incumbent. Incumbent may be asked to perform other duties as required.

_____	_____
Employee Signature	**Date (MM/DD/YYYY)**
_____	_____
Program Director Signature	**Date (MM/DD/YYYY)**

Canadian Mental Health Association Toronto

REGISTERED PRACTICAL NURSE (RPN), CASE MANAGER

PRIMARY HEALTH CARE: NP STEPPED CARE PROGRAM – WEST

(Full Time, Permanent)

The Canadian Mental Health Association Toronto Branch is a non-profit community based mental health agency providing a wide range of services across Toronto.

The Primary Health Care Team, has an opening for a Registered Practical Nurse (RPN). The RPN will take on a vital role in bridging the transition of ACTT Stepped Care clients out of ACTT services and into the primary health care setting in the community. Contact with clients and families are provided in office and in the community. The RPN will work closely with the Mental Health Nurse Practitioner to provide community based support, rehabilitation, and treatment for people living with mental illness. A strong focus on stabilization, community integration, quality of life and recovery from mental illness. The RPN will report to the Manager of Primary Health Care.

Key Responsibilities:
As part of the team you will:

- Develop therapeutic alliance with clients and their support systems/significant others
- Provide psycho-education around meds and symptoms
- Monitor treatment regimes
- Assess mental status and monitor physical health needs
- Support the agency's primary health care and chronic disease management initiative
- Assess client needs and link to appropriate resources
- Work from a recovery based perspective
- Collaborate service provision with other team members

The position requires the following:

- Current certification with the College of Nurses of Ontario as a Registered Practical Nurse
- Current personal liability insurance protection with RPNAO or equivalent provider
- 2 years experience working with people with mental illness, preferably community-based
- Excellent skills in mental health assessment and teaching, medication monitoring, case management, and crisis intervention
- Excellent organizational skills are required
- Ability to work independently and in a dynamic team environment
- Knowledge and understanding of the ACT Model and recovery-oriented practice
- Experience with addictions, forensics and dual diagnosis is an asset
- Fluency in a second language is an asset
- Ability to work with diverse communities
- Ability to work from an anti-oppressive framework

Successful applicants must have a valid Ontario driver's license, access to a vehicle and insurance for transporting clients.

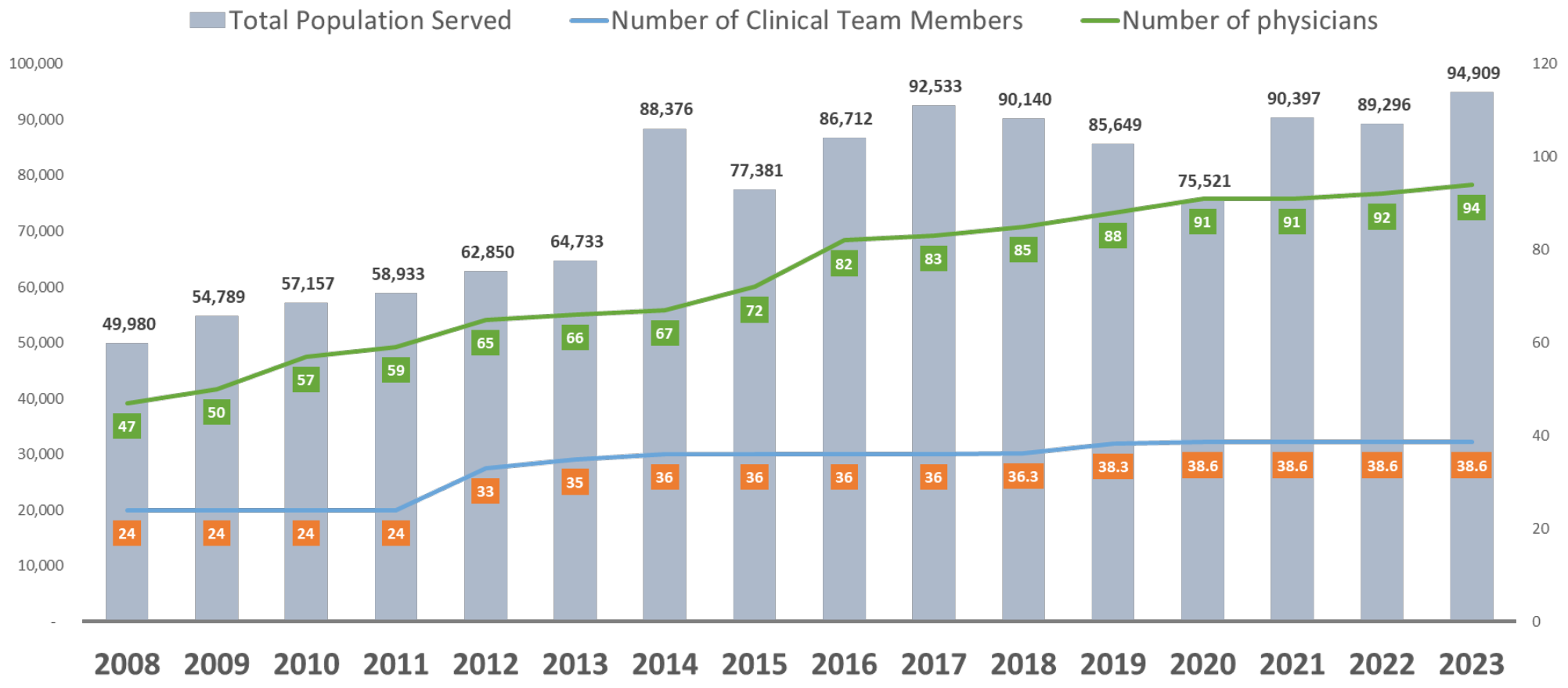
The Canadian Mental Health Association is an equal opportunity employer and encourages applications from equity seeking groups including qualified individuals with personal experience of the mental health system. If you are contact by our offices regarding a job opportunity please advise prior to the interview should you require any accommodation

Appendix F-

NYFHT Growth 2008-2023

We Have Doubled Total Patients Served in our 15 Years

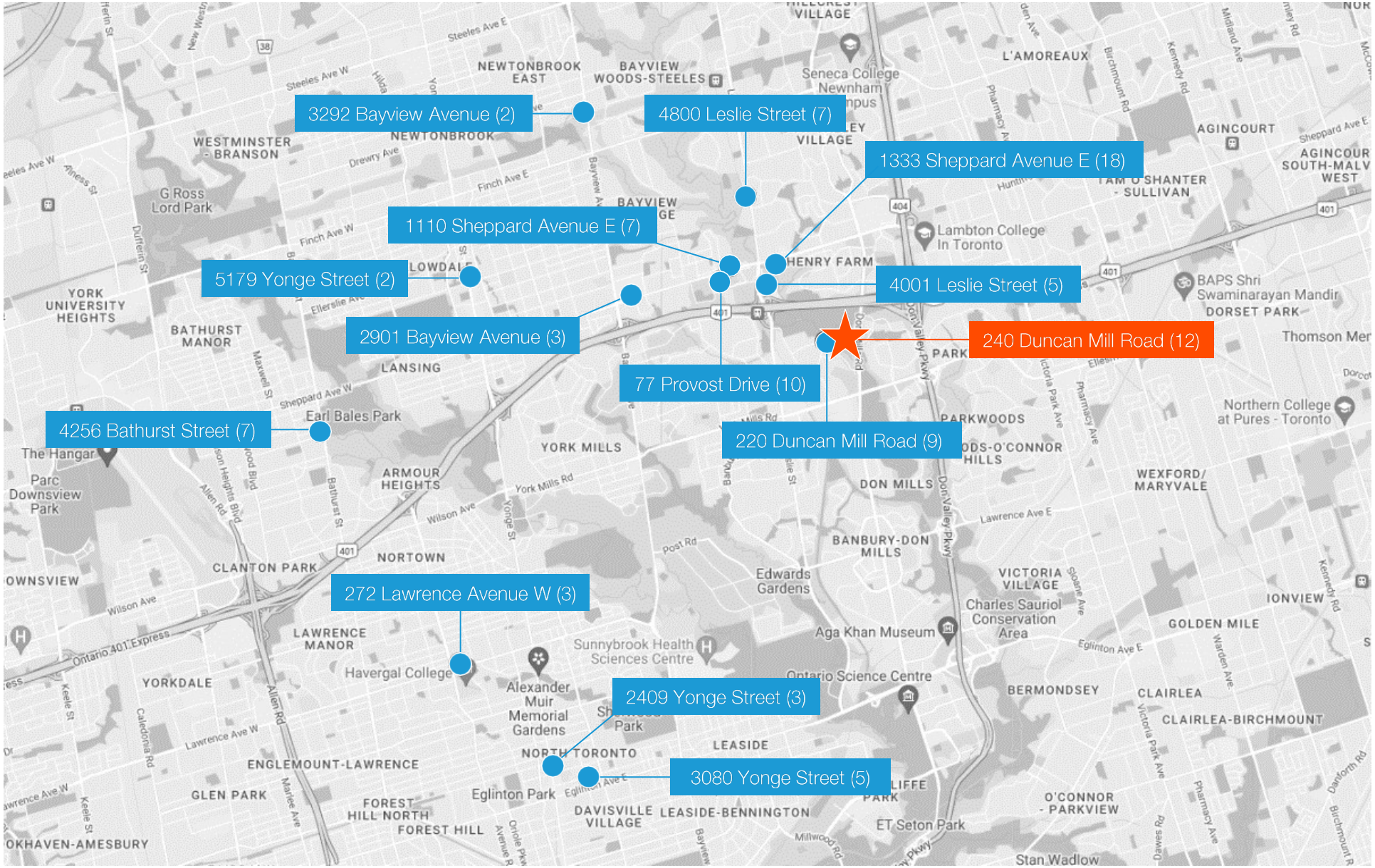
NYFHT
NORTH YORK FAMILY HEALTH TEAM



Appendix G-

NYFHT Physician Locations.

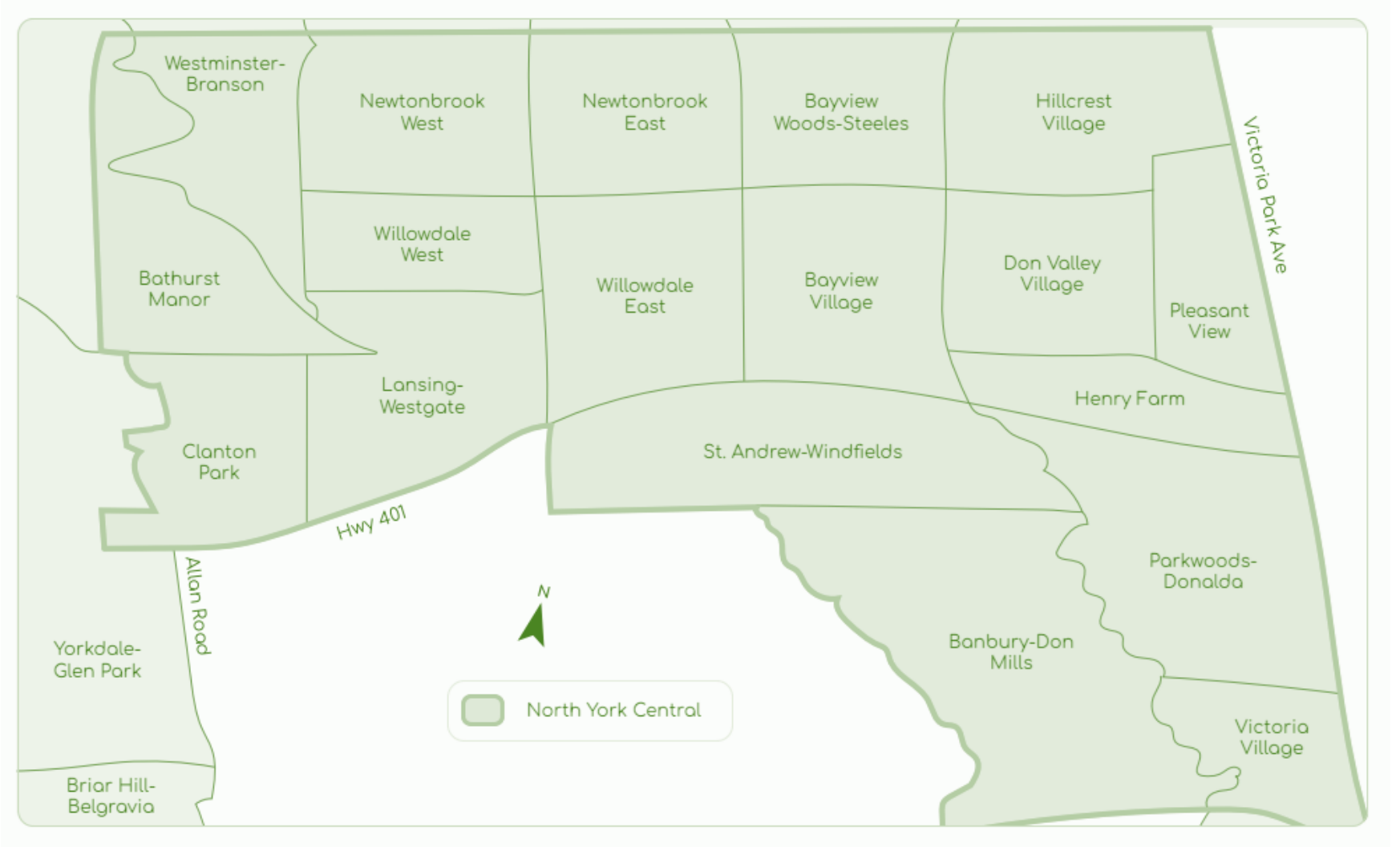
North York Family Health Team Physician Locations



Appendix H-

NYTHP Neighbourhood Map

Our Model of Care is Based on the Needs of NYTHP's 18 Diverse Neighbourhoods



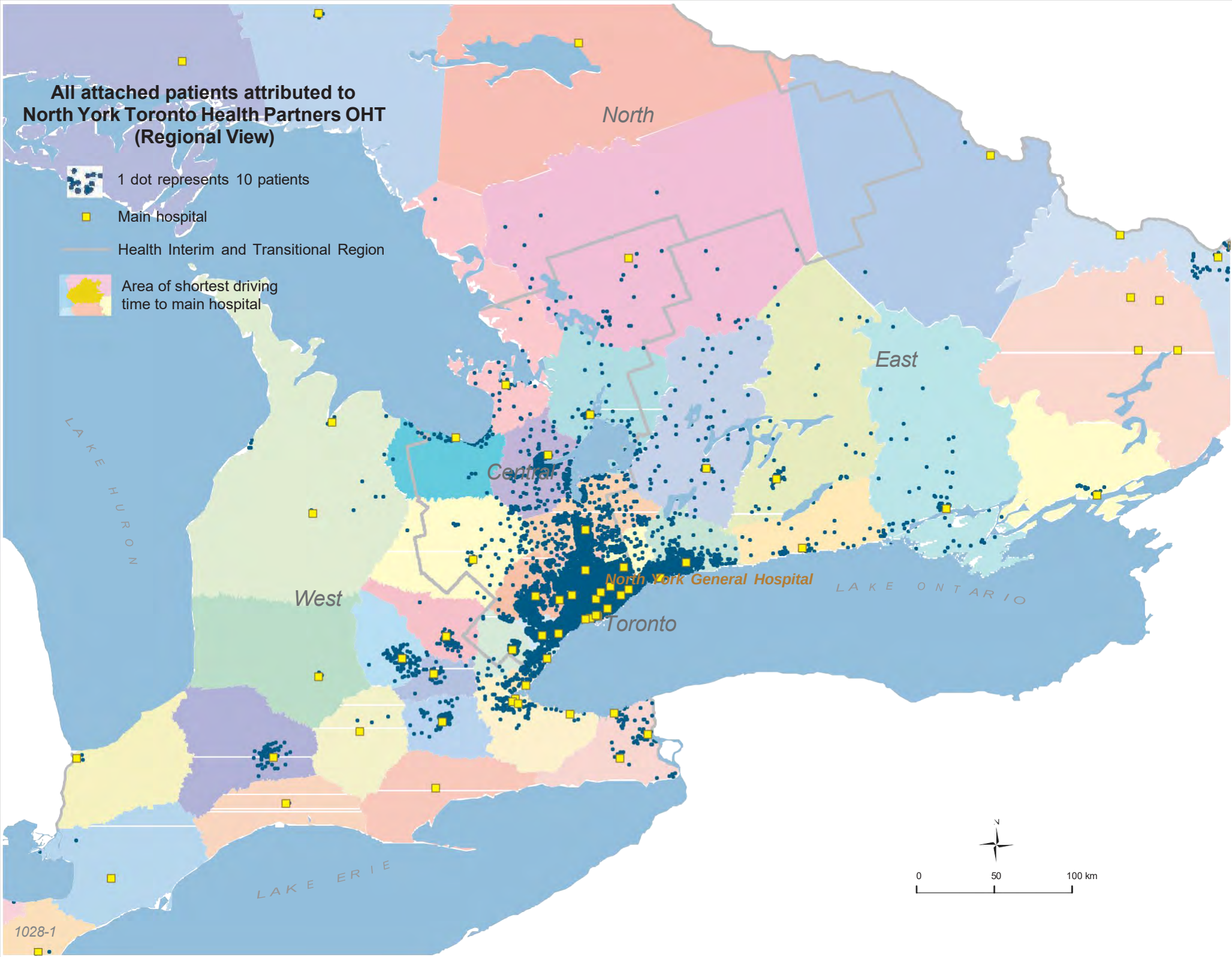
Appendix I-

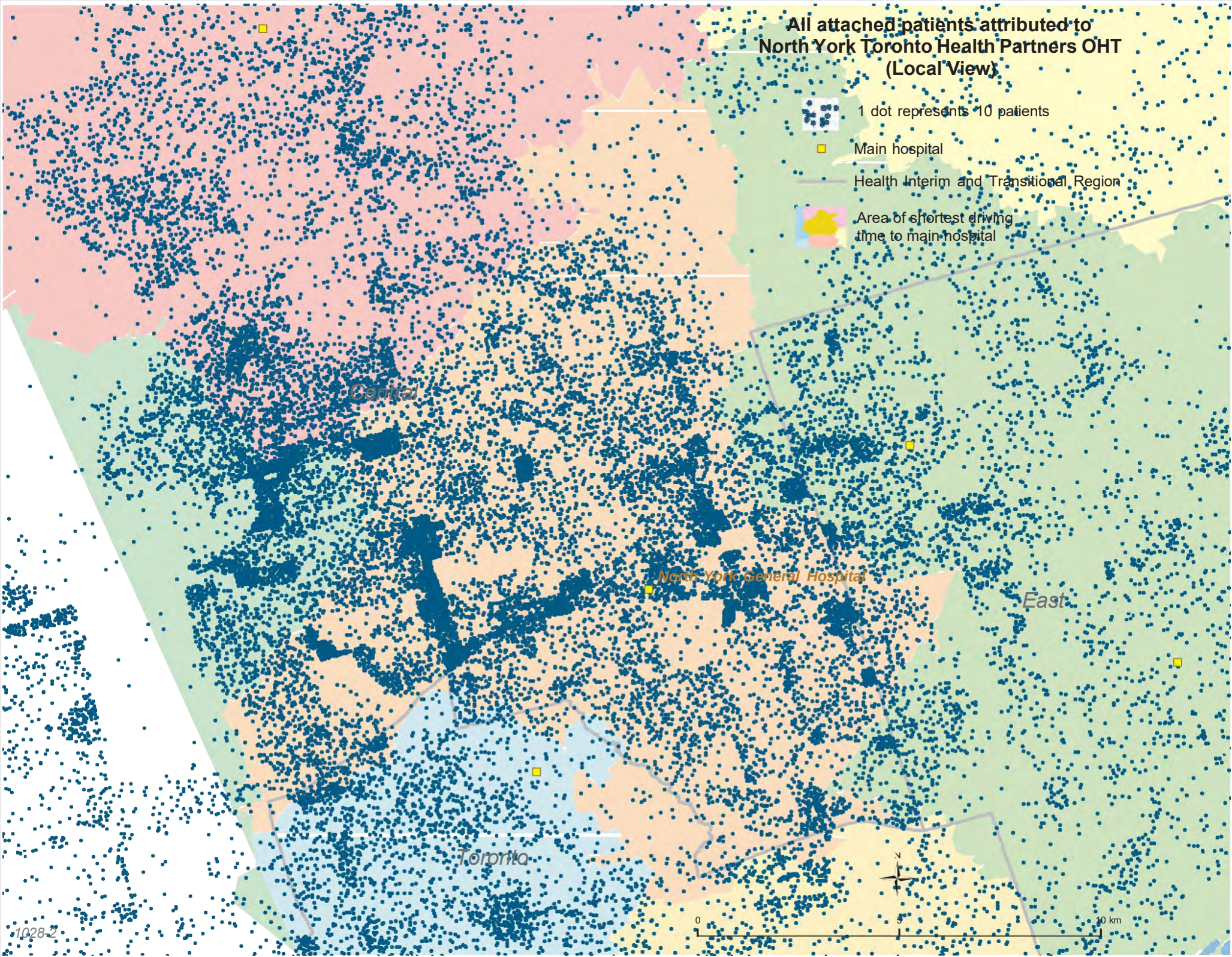
Neighbourhood Profiles

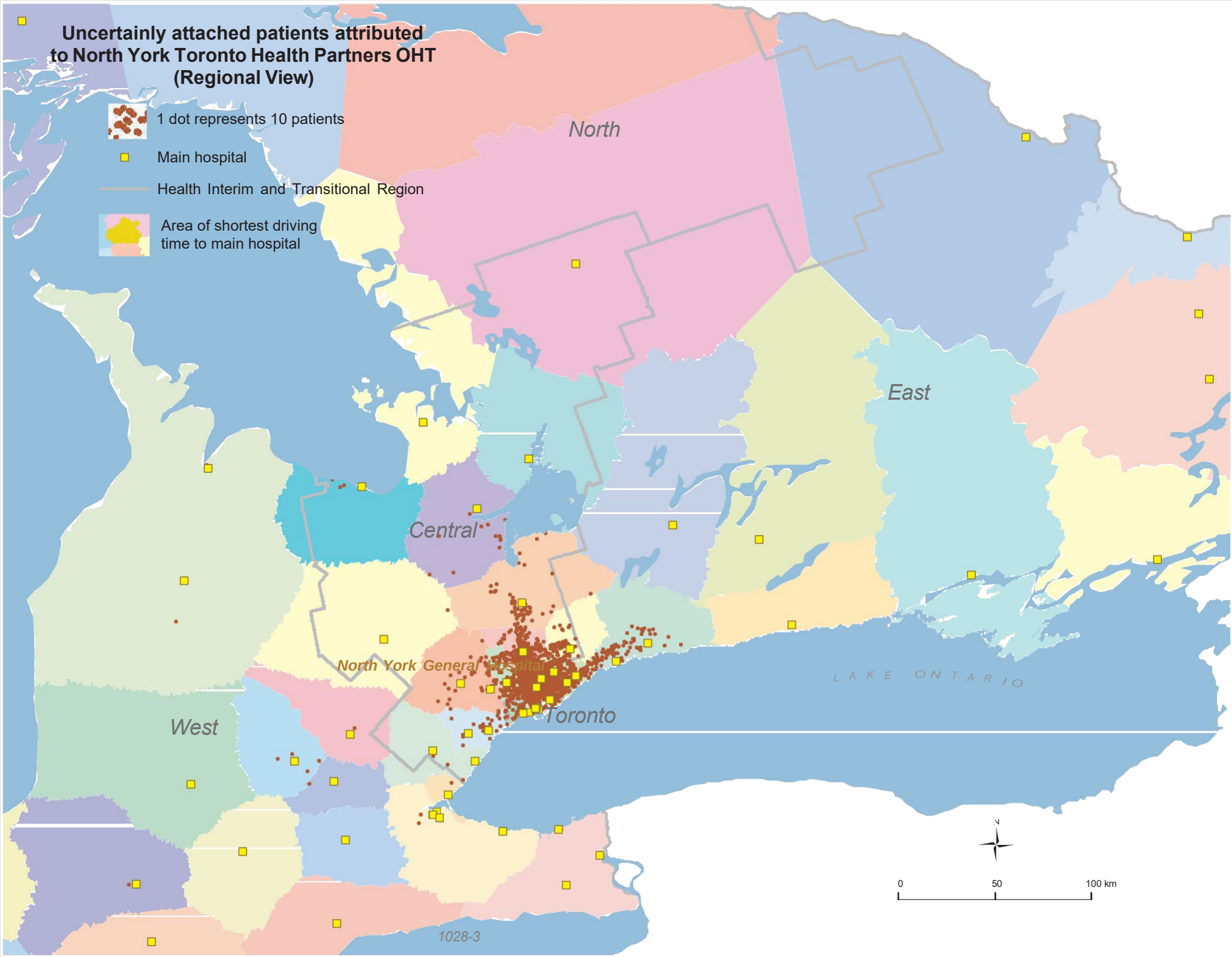
NEIGHBOURHOOD	TOP 5 LANGUAGES	LANGUAGE (mother tongue other than English) (%)	SENIORS (%)	CHILDREN + YOUTH (%)	2016 POPULATION	2026 POPULATION ESTIMATE (HIGH END)	ESTIMATED YEARLY POPULATION GROWTH (%)	PRIMARY CARE (PEM) ATTACHMENT (%)	DIABETES (%)	CHF (%)	COPD (%)	2 CONDITIONS (%)	4 OR MORE CONDITIONS (%)	MENTAL HEALTH (%)
Banbury-Don Mills	Mandarin, Cantonese, Persian, Romanian, Tagalog	47.2	25.2	22.9	29,695	45,735	4.15-6.51	75.7	12.4	29.9	9.2	19.9	12.8	8.2
Bathurst Manor	Russian, Tagalog, Spanish, Italian, Mandarin	55.4	18.4	26.9	15,873	19,155	1.32-2.07	72.2	13.1	28.3	9.3	18.8	13	9.6
Bayview Village	Mandarin, Persian, Cantonese, Korean, Tagalog	65.3	17	22.9	21,396	36,895	4.61-7.25	75.8	9.7	23.4	7.2	14.3	9.8	7.4
Bayview Woods-Steeles	Mandarin, Cantonese, Persian, Korean, Russian	61.9	28	24	13,154	13,540	0.19-0.29	78.9	14.4	30.6	8.6	20.8	16.4	8.3
Clanton Park	Tagalog, Russian, Italian, Greek, Spanish	44.8	14.5	28.4	16,472	24,290	3.02-4.75	67.9	13.2	27.1	8.2	17.4	9.9	9.1
Don Valley Village	Mandarin, Persian, Cantonese, Tagalog, Korean	69.3	17.4	27.2	27,051	30,230	0.75-1.18	74	13.3	24.6	7	15.7	8.1	7.1
Henry Farm	Mandarin, Persian, Cantonese, Arabic, Korean	67.4	9.2	30.6	15,723	28,035	4.98-7.83	70.6	12.1	20.5	6.7	13	5.3	6.7
Hillcrest Village	Mandarin, Cantonese, Persian, Korean, Spanish	70.4	25.4	25.5	16,934	16,935	0.00-0.00	80.4	14.9	30.4	6.9	19	10.2	7.6
Lansing-Westgate	Persian, Korean, Russian, Mandarin, Tagalog	46.8	13.5	28.1	16,164	18,055	0.74-1.17	70.1	9.6	21.1	6.7	13.2	7.5	7.8
Newtonbrook East	Persian, Mandarin, Korean, Cantonese, Russian	71.7	21	23.3	16,097	25,300	3.64-5.72	77.2	12.1	23.9	7.1	15.6	11.1	7.4
Newtonbrook West	Russian, Korean Tagalog, Persian, Mandarin	70.8	17.5	25.8	23,831	26,880	0.82-1.82	73.9	12.6	25.5	7.4	15.9	8.8	8.3
Parkwoods-Donalda	Mandarin, Persian Arabic, Spanish, Tagalog	47.6	15	30.1	34,805	36,180	0.26-0.49	72	13.8	27.3	9.4	18	8.7	9
Pleasant View	Mandarin, Cantonese, Greek, Italian, Persian	68.6	20.3	26.1	15,818	15,820	0.00-0.00	76.2	14.9	28.6	9.6	18.8	9.2	8
St. Andrew-Windfields	Mandarin, Persian, Cantonese, Korean, Spanish	51.4	18.2	29	17,812	19,775	0.71-1.10	73.1	9.7	22.9	7.1	14	7.3	7.4
Victoria Village	Tagalog, Arabic, Persian, Greek, Urdu	54.8	19.4	26.9	17,510	22,440	1.86-2.82	71.2	16.4	31.7	12.2	22.5	13.3	10.5
Westminster Branson	Russian, Tagalog, Korean, Persian, Ilocano	70.8	19.5	25.8	26,274	31,260	1.21-1.90	73.7	14.7	29.6	8.8	19.4	12	8.2
Willowdale East	Mandarin, Cantonese, Persian, Korean, Arabic	67.6	12.4	25.5	50,434	54,050	0.46-0.72	74.3	8.8	17.4	5.3	9.9	5.4	6.8
Willowdale West	Mandarin, Persian, Korean, Cantonese, Russian	64.4	19.9	23.8	16,936	20,400	1.31-2.05	75.3	11.7	26.3	8.4	16.6	12.2	8.1

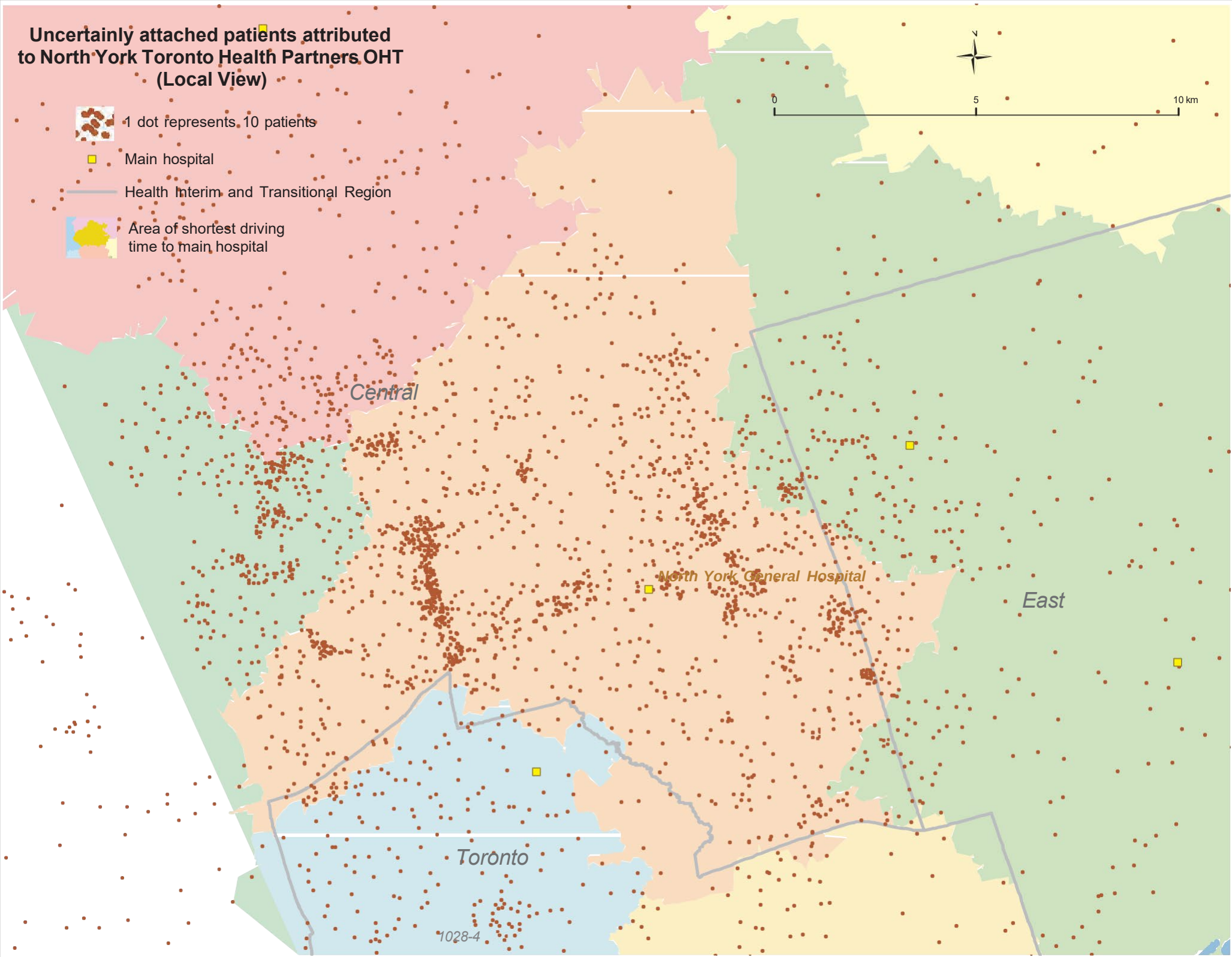
Appendix J-

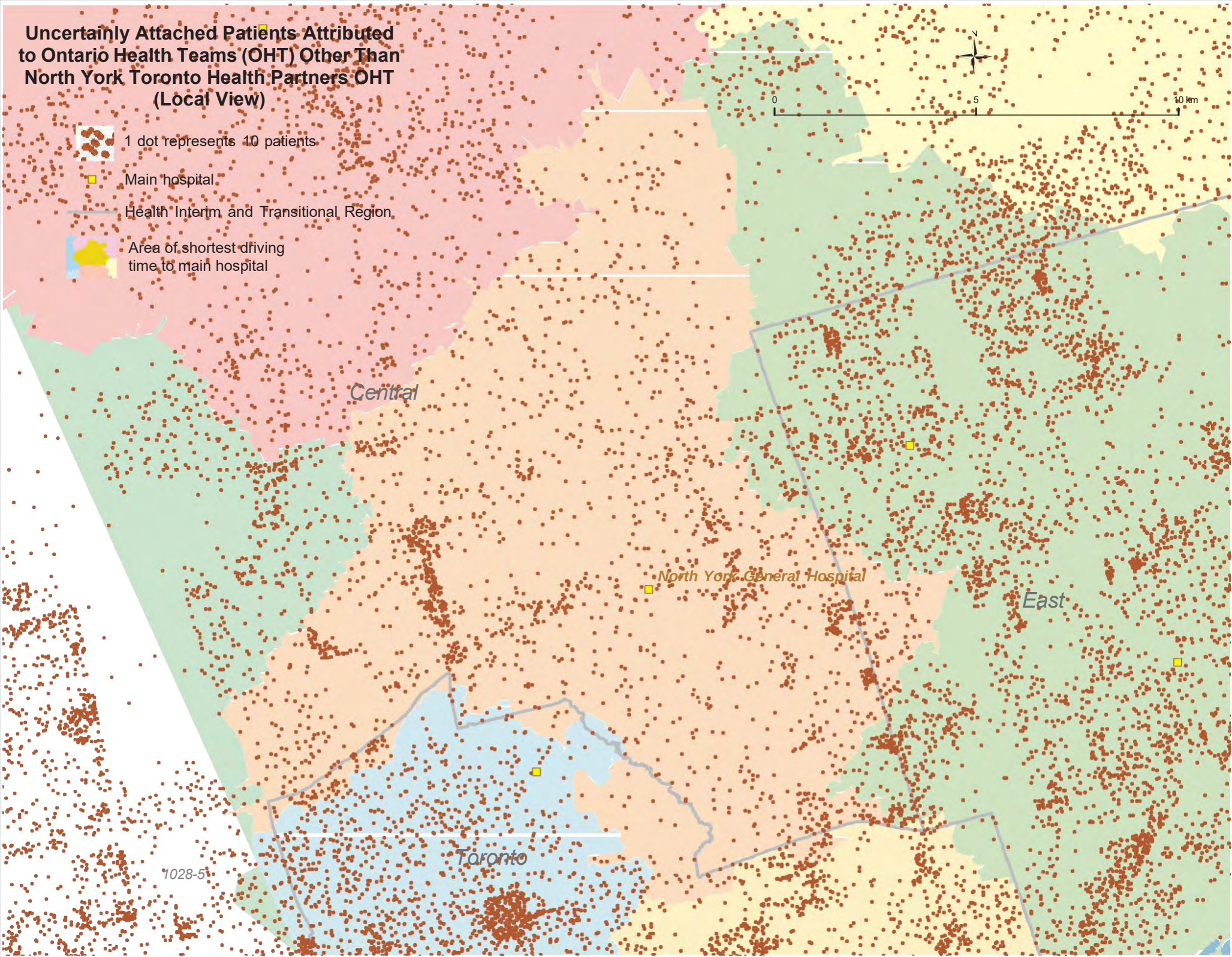
Maps of Attached and Unattached Patients


All attached patients attributed to
North York Toronto Health Partners OHT
(Regional View)
1 dot represents 10 patients
Main hospital
Health Interim and Transitional Region
Area of shortest driving
time to main hospital
North
East
Central
West
Toronto
North York General Hospital
LAKE HURON
LAKE ONTARIO
LAKE ERIE
0
50
100 km
1028-1


All attached patients attributed to
North York Toronto Health Partners OHT
(Local View)
1 dot represents 10 patients
Main hospital
Health Interim and Transitional Region
Area of shortest driving
time to main hospital
Central
North York General Hospital
East
Toronto
N
0
5
10 km
1028-2


Uncertainly attached patients attributed to North York Toronto Health Partners OHT (Regional View)
1 dot represents 10 patients
Main hospital
Health Interim and Transitional Region
Area of shortest driving time to main hospital
North
East
Central
West
Toronto
North York General Hospital
LAKE ONTARIO
N
0
50
100 km
1028-3


Uncertainly attached patients attributed to North York Toronto Health Partners OHT (Local View)
1 dot represents 10 patients
Main hospital
Health Interim and Transitional Region
Area of shortest driving time to main hospital
N
0
5
10 km
Central
North York General Hospital
East
Toronto
1028-4


Uncertainly Attached Patients Attributed to Ontario Health Teams (OHT) Other Than North York Toronto Health Partners OHT (Local View)
1 dot represents 10 patients
Main hospital
Health Interim and Transitional Region
Area of shortest driving time to main hospital
N
0
5
10 km
Central
North York General Hospital
East
Toronto
1028-5

1028 **North York Toronto Health Partners OHT**

All attributed patients	503291
Attributed patients attached to primary care	459450
Attributed patients uncertainly attached to primary care	43841

Appendix K-

NYTHP cQIP Workplan

Area of Focus - Increase Overall Access to Community Mental Health and Addiction (MHA) Services

Measure

Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of individuals for whom the emergency department was the first point of contact for mental health and addictions care per 100 population aged 0 to 105 years with an incident MHA-related ED visit.	P	% / People Change idea 1: Patients currently waiting for service at the Adult Mental Health Outpatient Program at NYGH or awaiting case management at The Access Point (TAP) Change idea 2: Patients attached to primary care providers who have access to SCOPE	See Tech Specs / Oct 2021– Sept 2022	22.90	28.10	Our 2023/4 Target is based on a current performance indicator of 28.1. In 2023/24, the NYTHP OHT has set a maintenance target of 28.1% for this indicator. In FY23-24, our OHT will continue to build on our developmental change ideas submitted in the last cQIP cycle. This target will allow us to continue developing our work plan for a pilot drop-in centre and strengthen our relationships and engagement with Primary Care.	- Addiction Services Central Ontario, - CMHA Toronto, - North York General Hospital, - The Access Point, - LOFT Community Services, - Lumenus Community Services, - Krasman Centre, - COTA Inspires, - NYTHP Primary Care Network, - Hong Fook Mental Health Association

Change Ideas

Change Idea #1 Increase access to low-barrier drop-in MHA services as an alternative to the NYGH ED			
Methods	Process measures	Target for process measure	Comments
- Continuing to develop a business case and work plan to implement a multi-agency low-barrier drop-in centre near the NYGH ED. Considering a phased approach to implementation with a long-term vision to provide patients with opportunities for follow-up, connection to ongoing support, and structured activities. - Focus for FY23-24 to advocate for funding to support staffing/resourcing for the drop-in centre.	- To Be Determined after model is approved	- Identify phase 1 model of care by Summer 2023 - Secure funding for phase 1 model of care by March 2024	Assumption: Ability to secure funding to support staffing/ resourcing for the drop in centre Factor for success: Multi-agency partnership, CMHA to lead, NYGH to provide space

Change Idea #2 Raise awareness of MHA service navigation resources and MHA pathways for primary care through SCOPE

Methods	Process measures	Target for process measure	Comments
- Leverage feedback from the NYGH SCOPE team (i.e., nurse navigator and social worker) on our resource list to identify any areas for improvement. - Partner with the NYTHP Primary Care Advisory Council (PCAC) to raise PCP awareness of MHA service navigation resources. Considering: o Access to resource list through the OHT/PCAC websites o Blurbs in weekly e-newsletters emailed to NYTHP's Primary Care Network o NYTHP Primary Care events o NYGH Family Medicine/Psychiatry case conference rounds - Work with Primary Care to create EMR stamps/templates with MHA resources to include in communications with patients - Increase collaboration and partnership between primary care and the hospital to mental health services (e.g. providing information about the TAP program)	- Number of providers viewing the resource list online - Number of stamps/templates created and shared with PCPs	- In partnership with NYGH SCOPE team collaborate with the PCAC to provide knowledge about the MHA services within the community	

Area of Focus- Improving Overall Access to Care in the Most Appropriate Setting

Measure

Dimension: Efficient

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.	P	% / People Change 1-3: ALC-designated patients at NYGH (this signals that we're focusing on ALC in our hospital) Change 4: LTC residents (8 LTC facilities within North York region) at risk of hospitalization and at risk of becoming ALC	See Tech Specs / Oct 2021–Sept 2022	20.10	20.00	In 2023/24, the NYTHP OHT has set a maintenance target of 20.0 for this indicator. Our OHT recognizes that this focus area requires system-wide partnership and shared accountability. This target will allow us to confirm the governance structure for our newly established ALC committee and focus on developing upstream and downstream solutions to address local drivers of ALC.	LOFT, North York General Hospital, Home and Community Care Support Services, GTA Rehab Network, The Access Point (TAP), Behavioural Supports Ontario (BSO), Baycrest, Primary Care, Bayshore Healthcare, Better Living, Virtual Behavioural Medicine, Mackenzie Health, St Elizabeth Healthcare (SE Health), NYTHP Patient Caregiver Health Council, NYGH Patient Experience Partner (PXP)

Change Ideas

Change Idea #1 Understand the profile of individuals who are ALC-designated at NYGH

Methods	Process measures	Target for process measure	Comments
- In partnership with the NYGH Decision Support team and NYTHP, analyze available ALC data to understand the ALC population at NYGH.	- Data to help inform reasons for ALC (upstream & downstream), and inform future tests of change	- Data analysis completed by Spring 2023 - ALC committee to review analyses by Summer 2023 - Data analysis to drive developing 2 action plans to support QI	

Change Idea #2 Improve understanding of available community resources for clinical teams and discharge planners

Methods	Process measures	Target for process measure	Comments
- Implement lunch + learn sessions with SWs/PPLs and community partners/services to promote knowledge sharing and awareness of services available in the OHT/Community - Strengthen relationships with HCCS & units SWs to promote collaboration by providing opportunities for SWs to be introduced to community supports and partners to enhance awareness of services available	- # of lunch n learns with community partners and SWs - # of connections made with NYGH	- 1 per quarter - 3 new connections developed per quarter	

Change Idea #3 Establish an ALC Case Management Team to collaboratively review complex discharges			
Methods	Process measures	Target for process measure	Comments
- Conduct an environmental scan across the OHT and North York region to explore all existing multi-agency, multidisciplinary complex resolution tables. The goal of the environmental scan is to assess which existing table(s) NYGH can partner with and leverage to drive complex acute care cases discharges - Leverage partnerships across the OHT and community to move towards a collaborative and systematic approach to prevent and decrease ALC - Resolution table and action oriented – bringing forth challenging/complex discharge cases to collaborate and discuss to support transitioning pathway and support care teams to mitigate current obstacles preventing the patient from being discharged	(1)- Partnering with existing resolution table and establishing inclusion criteria supportive of regional patients' needs (2) - Number of referrals filtered to resolution table per quarter	(1) - 80% of referrals filtered to the CRM table (2) - 1-2/monthly)	

Change Idea #4 Reduce avoidable transfers to the NYGH ED for residents in select LTC homes

Methods	Process measures	Target for process measure	Comments
- Implement “Congregate SWAT” initiative and continue to strengthen relationships with eight local LTC homes - Increase LTC provider awareness and facilitate access to pathways that bypass the ED through SCOPE, LTC+, the Seniors Hotline, and other methods - Build capacity for point-of-care staff in LTC homes through in-home training and education delivered by NYGH’s nurse-led outreach team and behavioural supports programs.	- Establish Congregate SWAT team & leadership (ie. Medical Director, NP, point of care staff, clinical manager, clinical director) - Establish connections with medical director and nursing administration and clinical leadership per home - Build relationships with home by (1) survey each home for their clinical needs (2) establish monthly meetings with Congregate SWAT + 8 LTC in North York - LTC+ process to involve SCOPE line - # of programs/resources shared with LTC providers - # of calls from LTC providers to SCOPE pathways - # of CoP meetings held with LTC homes - # of resident transfers from LTC to NYGH ED	- Establish Congregate SWAT team in May 2023 - Establish connections with 8 LTC homes in the North York region	

Area of Focus- Increase Overall Access to Preventative Care

Measure

Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The percentage of screen-eligible people aged 21 to 69 years who had a cytology (Pap) test within the previous 3 years.	P	% / Population Change idea 1: Patients who experience barriers to access care (e.g., uninsured, unattached to Primary Care, cannot easily access screening) Change idea 2: Patients seen by Primary Care Providers who are "low-screeners"	See Tech Specs / 2nd Quarter - up to Sept 2022	50.80	50.20	In 2023/24, the NYTHP OHT has set a maintenance target of 50.2% for this indicator. This compares against current performance indicator of 50.2% (FY21/22 OH Dashboard – cQIP Report). Primary care providers continue to experience delays in receiving pap test results. Therefore, maintaining our current performance at the attributed population level may suggest an improvement in this focus area.	- NYTHP Primary Care Advisory Council, - North York Family Health Team, - North York General Hospital, - Community Ambassadors: North York Community House, Working Women Community Centre, - Flemingdon Health Centre, - Cancer Care Ontario

Change Ideas

Change Idea #1 Increase access to low-barrier preventative screening services			
Methods	Process measures	Target for process measure	Comments
Continue to offer cancer screening services at monthly CHIFs and build partnerships with community organizations and groups that provide information, resources, and services at these events. - Develop a plan to scale cancer screening services and improve access to preventative care for priority neighbourhoods (e.g., mobile clinic)	Examples: # of CHIFs held, # of pap tests performed, # unattached patients connected to primary care, positive patient reported outcome (PROM)	Improved community wellness in high-needs neighbourhoods	Assumption: Ability to secure funding for Community Ambassadors and CHIFs

Change Idea #2 Engage with primary care providers who are “low screeners” to understand barriers to screening and offer tools to increase screening rates			
Methods	Process measures	Target for process measure	Comments
- Develop a provider-focused “toolkit” with resources to improve cancer screening rates in PEM practices - Continue to collaborate with Cancer Care Ontario to identify and engage with “low screeners” - Address known barriers to screening to increase engagement with primary care providers - Develop a plan to engage with PCPs who do not practice in a PEM practice	Examples: # FSAs targeted for outreach, # of providers reached with “toolkit,” plan made for non-PEM PCPs	Improved screening by targeted providers (i.e., fewer “low screeners”)	Requires CCO partnership for provider contact and monitoring data

Measure

Dimension: Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The percentage of screen-eligible people aged 50 to 74 years who had completed at least one screening mammogram within the past 2 years.	P	% / Population Change idea 1: Patients who experience barriers to access care (e.g., uninsured, unattached to Primary Care, cannot easily access screening) Change idea 2: Patients seen by Primary Care Providers who are "low-screeners"	See Tech Specs / 2nd Quarter - up to Sept 2022	58.30	55.00	Current Performance based on 52.9% (FY21/22 OH Dashboard – cQIP Report). In 2023/24, the NYTHP OHT has set a modest improvement target of 55.0% for this indicator. Our OHT is using the 75th percentile as a target for our second year.	- NYTHP Primary Care Advisory Council, - North York Family Health Team, - North York General Hospital, - Community Ambassadors: North York Community House, Working Women Community Centre, - Flemingdon Health Centre, - Cancer Care Ontario

Change Ideas

Change Idea #1 Increase access to low-barrier preventative screening services			
Methods	Process measures	Target for process measure	Comments
- Continue to offer cancer screening services at monthly CHIFs and build partnerships with community organizations and groups that provide information, resources, and services at these events. - Develop a plan to scale cancer screening services and improve access to preventative care for priority neighbourhoods (e.g., mobile clinic)	Examples: # of CHIFs held, # of pap tests performed, # unattached patients connected to primary care, positive patient reported outcome (PROM)	Improved community wellness in high-needs neighbourhoods	Assumption: Ability to secure funding for Community Ambassadors and CHIFs

Change Idea #2 Engage with primary care providers who are “low screeners” to understand barriers to screening and offer tools to increase screening rates			
Methods	Process measures	Target for process measure	Comments
- Develop a provider-focused “toolkit” with resources to improve cancer screening rates in PEM practices - Continue to collaborate with Cancer Care Ontario to identify and engage with “low screeners” - Address known barriers to screening to increase engagement with primary care providers - Develop a plan to engage with PCPs who do not practice in a PEM practice	Examples: # FSAs targeted for outreach, # of providers reached with “toolkit,” plan made for non-PEM PCPs	Improved screening by targeted providers (i.e., fewer “low screeners”)	Requires CCO partnership for provider contact and monitoring data

Measure

Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The percentage of screen-eligible people aged 50 to 74 years who had a fecal immunochemical test (FIT) within the past 2 years, a colonoscopy within the past 10 years, or a flexible sigmoidoscopy within the past 10 years.	P	% / Population Change idea 1: Patients who experience barriers to access care (e.g., uninsured, unattached to Primary Care, cannot easily access screening) Change idea 2: Patients seen by Primary Care Providers who are "low-screeners"	See Tech Specs / 2nd Quarter - up to Sept 2022	64.70	66.20	In 2023/24, the NYTHP OHT has set a modest improvement target of 66.2% for this indicator. Our OHT is using the 75th percentile as a target for our second year.	- NYTHP Primary Care Advisory Council, - North York Family Health Team, - North York General Hospital, - Community Ambassadors: North York Community House, Working Women Community Centre, - Flemingdon Health Centre, - Cancer Care Ontario

Change Ideas

Change Idea #1 Increase access to low-barrier preventative screening services			
Methods	Process measures	Target for process measure	Comments
- Continue to offer cancer screening services at monthly CHIFs and build partnerships with community organizations and groups that provide information, resources, and services at these events. - Develop a plan to scale cancer screening services and improve access to preventative care for priority neighbourhoods (e.g., mobile clinic)	Examples: # of CHIFs held, # of pap tests performed, # unattached patients connected to primary care, positive patient reported outcome (PROM)	Improved community wellness in high-needs neighbourhoods	Assumption: Ability to secure funding for Community Ambassadors and CHIFs

Change Idea #2 Engage with primary care providers who are “low screeners” to understand barriers to screening and offer tools to increase screening rates			
Methods	Process measures	Target for process measure	Comments
- Develop a provider-focused “toolkit” with resources to improve cancer screening rates in PEM practices - Continue to collaborate with Cancer Care Ontario to identify and engage with “low screeners” - Address known barriers to screening to increase engagement with primary care providers - Develop a plan to engage with PCPs who do not practice in a PEM practice	Examples: # FSAs targeted for outreach, # of providers reached with “toolkit,” plan made for non-PEM PCPs	Improved screening by targeted providers (i.e., fewer “low screeners”)	Requires CCO partnership for provider contact and monitoring data