East Toronto
Health Partners

PLANNING FOR COMMUNITY SURGE

DRAFT – EARLY DISCUSSIONS ON 2020-21 SURGE

Aug 18, 2020

Agenda

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1. Setting the Planning Context and Criteria for 20-21
2. Discuss Evaluation and Insights from 19-20 Surge
3. Discuss Planned Surge Approach and Initiatives
4. Staying Connected During Surge

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Planning for Community Surge 2020-21

What is Winter Seasonal Surge?

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Seasonal Surge is an annual occurrence taking place from **November– April.** It stems from:

- Increased demand for service due to influenza, respiratory gastro-intestinal illness

- Compounded by weather, falls, seasonal affective disorder

- Further strained by the "12 days of Holidays" between December 22 to January 2 – which is marked by uncoordinated service planning and variable and limited health human resources

LEADS TO

- Increased hospital occupancy rates that exceed regular capacity
- Longer ED wait times and stays, with delayed acute care admissions
- EMS delays (i.e., off load)
- Cancelled/ postponed elective surgeries
- Delayed access to LTC homes, convalescent care, RIUs due to out breaks
- Increased demand on home and community care
- Reduced community capacity due to staff illness (sick days)
- Over extending human resources (overtime, increased workload, burnout)

ED Visit Heat Map 19-20

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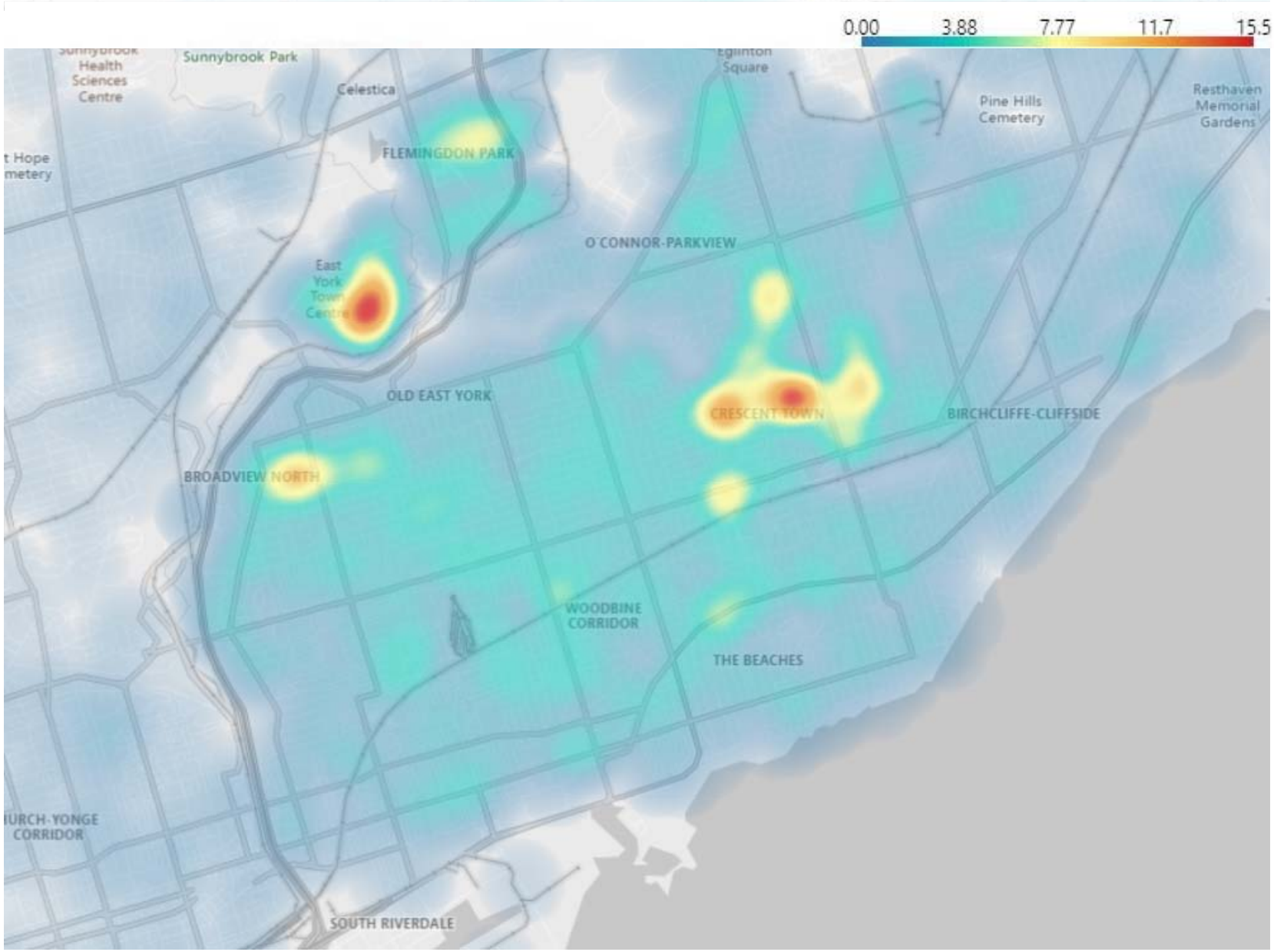

ED Visit for Influenza Heat Map 19-20

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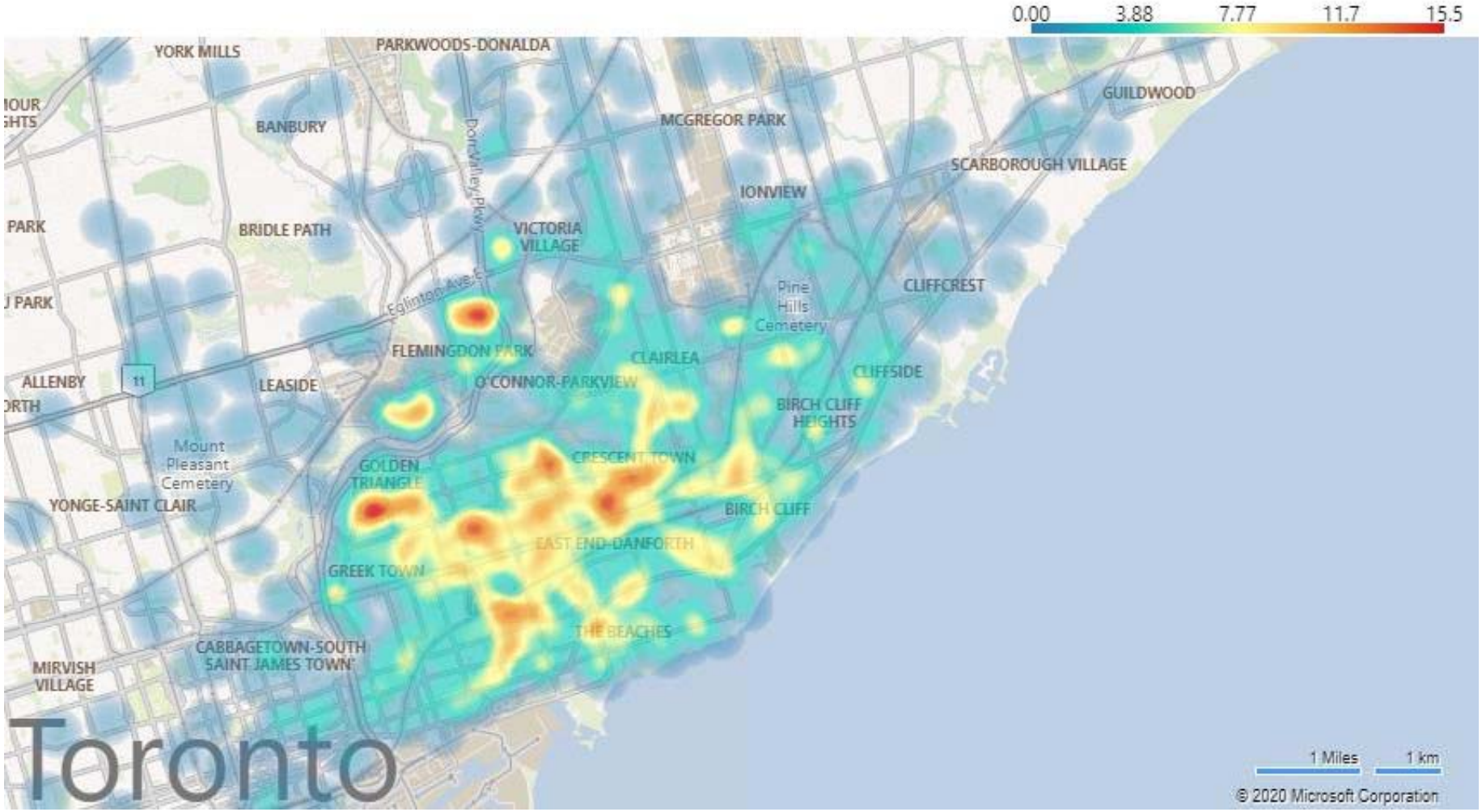

Evaluation and Insights from Community Surge 2019-20

Community Surge 2019-20 Parameters

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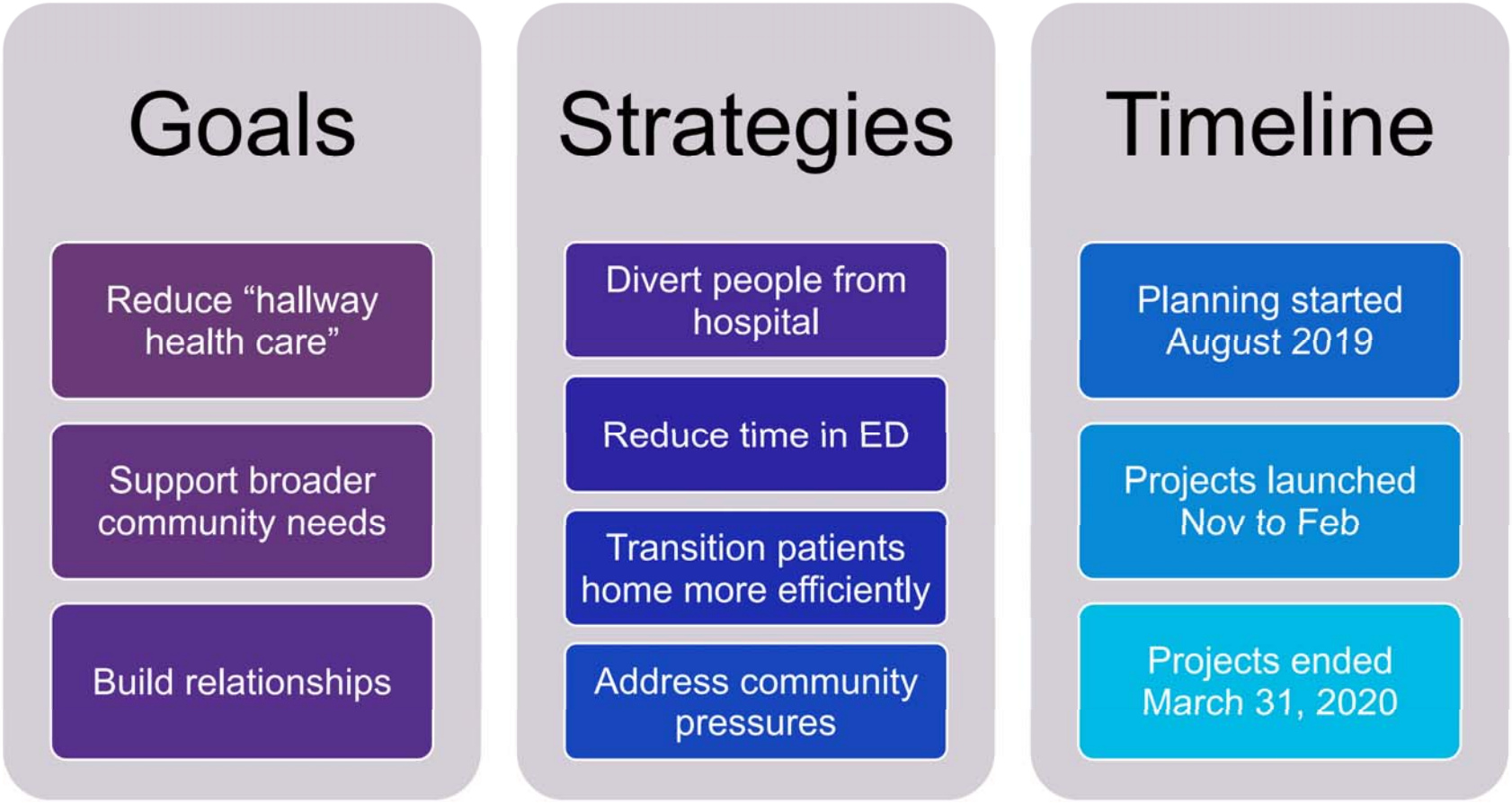

Summary of 2019-20 Project Evaluations

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Successful

- East Toronto CHC Network Community Flu Clinic
- East Toronto Mobile Flu and Falls Clinic
- NICE Hospital Fund
- Prevnar13 Surge Project
- Oakridge Health and Harm-Reduction Hub
- SCOPE Mental Health
- Thorncliffe Park Winter After-Hours Clinic

Mixed Results

- Committed Non-Emergent Patient Transport
- Fast Access to Rehab
- Health Boost Initiative
- Walk-in Counselling "12 Days of Holidays"

Unsuccessful

- Community Transport Project
- Paediatric Short-Stay Unit

Unclear

- HomeCare Specialist
- NICE Community Fund

Core Evaluation Learnings from 2019-20

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Core Learnings

- Specific, achievable goals
- Rescope projects carefully
- Opportunities for integration
- Project management is key
- Opportunities for learning

Building on 2018-19 Evaluation Insights

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Compare:
Learnings from last year

- Start-up time and staffing were less of an issue
- Communication and relationships are still essential
- Implementation and alignment of measures were more of an issue
- Missed opportunities for learning
- Half of projects were tests of change

Evaluation Recommendations for 20-21

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More structure at planning stage	Proposals should have clear goals and achievable outcomes Proactively identify areas of common interest and encourage coordination early on
Greater attention to implementation	Proposals should clearly identify project leads who can ensure smooth implementation When a decision is made to rescope a project, engage all stakeholders to ensure buy-in
Dedicated project management	Hire a project manager to oversee and coordinate the overall surge initiative For new or complex projects, consider hiring or assigning a project manager
Shared vision for evaluation	Set clear expectations for evaluation and communicate to project leads and sponsors Encourage project leads to have early and frequent contact with the evaluation team

Surge Approach and Initiatives 2020-21

Several Parallel Proposals and COVID-19 Related Efforts Impact 20-21 Surge Planning

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Hospital Internal Surge	• $1.0M
Community Surge	• ETHP Investment of $1.1M
OH Funding towards OHTs	• $375K
Reactivation Care Centre + Short-Term Transitional Bed	• ~60 Beds @ MGH, ~ 60 Beds @ LOFT, ~ 25 Beds @ Unity
COVID-19 Response	• LTCH and Infectious Disease Response
Remote Monitoring	• $200k Medicine programs • In-kind for Surgical programs

* $1.5M Community Surge supports existing investments in East FPN, OHT Leadership and Project Management

Beyond these proposals, several previous surge initiatives continue self-funded

Surge Investments Should Focus on 'Hallway Health Care', COVID-19 and Community Need

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- Based on past surge experiences, the current context around COVID-19, and a continued need to reduce 'hallway health care' for our community, we will be focusing the following for 20-21 surge:
  1. Divert people from hospital through proactive supports in the community
  2. Reduce time in ED through increased resources and operational improvements
  3. Transition patients home more efficiently by partnering with providers in the community
  4. Addressing community health and provider pressures to increase overall capacity
  5. Mitigate impacts of a potential COVID-19 Wave 2 on ETHP services
- Further, as ETHP, we identified four priority populations for Year 1 of our Ontario Health Team, for consideration during surge:
  - Seniors and Chronic Disease
  - Substance Use and Health
  - Youth Mental Health and Addictions
  - Neighbourhood Improvement Areas (Community Hubs / NCTs)
- We will work with Engaged Partners to implement the Surge Projects and coordinate surge efforts across the OHT.

Several Key Principles and Evaluation Criteria Guide our Community Surge Planning

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Surge Categories

- Improve Wellness and Divert from Hospital
- Reduce Time in ED
- Mitigate COVID-19 Impacts
- Transition Home More Efficiently
- Addressing Community Health Capacity

Key Principles

- Reduces Hallway Health Care
- Considers Year 1 Populations
  - Seniors and Chronic Disease
  - Substance Use and Health
  - Youth Mental Health and Addictions
  - Priority Neighbourhoods
- Addresses Community Pressures
- Supports Tests of Change
- Builds Inter-Organizational Partnerships
- Optimizes Resource Sharing and Synergies
- Adequately resourced to support project management, evaluation and communications

Evaluation Criteria

- Hospital Diversion
- Reduces Time in ED
- Scalable
- Sustainable
- Measurable Health Outcomes
- Mitigates COVID-19 Impacts

+

- Proven Past Initiatives Requiring Ongoing Funding

Community Surge Proposals

East Toronto Health Partners

Improve Wellness and Divert from Hospital ($600K)	
Initiative	**Leads**
Integrated Flu Initiatives	**Shannon Weins, Barb Cawley, Ashnoor Rahim**
Expand LTCH Clinical Supports	**Dr. Jeff Powis, Dr. Jarred Rosenberg (MGH)**
Mobile Community IPAC Team	**Dr. Jeff Powis (MGH)**
SCOPE Mental Health Pathways	**Greg Stevens, Dr Catherine Yu (ETFPN)**
Expanded Primary Care Clinics	**Greg Stevens, Dr Catherine Yu (ETFPN)**

Address Community Pressures ($275K)	
Initiative	**Leads**
Community Hub and NCT Expansion	**Greg Stevens, Ashnoor Rahim**
Community NICE Fund	**Mary Eastwood**
Mobile Phone Equity Pilot	**Dr. Kate Lazier, Kevin Edmonson**

Reduce Time in ED and Avoid Admissions ($25K)	
Initiative	**Leads**
ED Virtual Assessment for LTCH/ Shelters	**Kevin Edmonson**
Hospital-Community Virtual ED Hub	**Raj Sohi, Mary Eastwood**
Direct Home Care Transitions	**Ian Ritchie**

Transition Home Effectively ($50K)	
Initiative	**Leads**
Enhanced Psycho-geriatric Hospital-Community Pathways	**Mary Eastwood, Julia Chao, Raj Sohi**

Continued 19-20 Self-Funded			
Pending LTCH/ID Proposals to OH	Oakridge SUH Hub Pending RCC Proposal to OH	Oakridge SUH Hub NEPT Coordinator	Community NEPT Transport Hospital NICE Fund

OHT Funding ($375K)	
Central Intake, referral and booking	Data exchange and data sharing

Enhanced Project Management ($0) + Communications ($10K) + Evaluation Impact Fellow ($50K) + Hypercare ($25K)

Discussion Questions

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1. How do you envision the planned projects serving your clients and the communities you serve?
2. What are you most concerned about for your clients during the fall and winter season?
3. What is being planned in your organizations around winter surge?
4. Are there any potential synergies or overlap with your planned projects and the 20-21 surge projects?
5. How do we ensure ongoing communication throughout surge, and what forums can leverage to stay connected?

Next Steps

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Thank You!

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Appendix: Planned Surge Initiatives 2020-21

Initiative Proposal Template

East Toronto Health Partners

Initiative Name

Mobile Flu

Initiative Description

Goals and Objectives

- Increased participation in flu shot campaign
- Connection to services needed but not previously identified
- ED/hospital diversion
- Attachment to primary care

Statement of Need Not all vulnerable people are accessing flu shots through their family physician or pharmacy. To increase the # of people protected it is important to proactively provide the vaccine, particularly for those who are homebound, have mobility issues that limit their ability to get the flu shot in the community, cognitive challenges or mental health and addiction issues**.** Found last year that some people receiving flu shot were not attached to primary care – this increases their potential for ED use and increases their general health risks.

Surge Category Improve Wellness & Divert from hospital

Organizations VHA and WoodGreen leading. Toronto Community Housing is a support partner. Other partners in the community to identify settings that would benefit & provide introduction.

Key Principles Targets year 1 seniors population, supports increased flu immunization in priority neighbourhoods, builds inter-organizational partnerships and optimizes resource sharing and synergies

Note: *2019-20 Mobile Flu and Falls Prevention Clinics included home safety assessments by an OT. To maximize the number of flu shots provided within the current budget we are unable to offer Falls Prevention. If additional funds become available, we would be pleased to provide the Falls Prevention*

Existing Synergies/ Services

- Build on 2019-20 partnership to deliver mobile flu clinics
- Build on WoodGreen's relationships with TCH, and clients in TCH buildings, other CSS and CMHA agencies and congregate settings in the East to offer flu shots to tenants
- Use relationship with OHT org's MOW clients to offer flu shots to homebound clients

Budget Needed

- $50,000 needed to support the initiative
- In-kind: WoodGreen staff identification & support to access seniors who would benefit and VHA best practice & experience with flu vaccine programs
- Leverage relationship with pharmacist to provide flu shots at in-building clinics

Outcomes and Measures

Outcomes

- Increase in # of people receiving the flu shot
- People without a PCP get attached

Data to be tracked

- # of vaccines clinics offered
- # of vaccines administered in clinics
- # of vaccines administered in homes
- # of people who did not get a vaccine last year
- # of new LHIN referrals for home safety
- # of referrals to other new services
- # not attached or poorly attached to PCP
- # of people who get connected to PCP
- Postal codes

Evaluation Criteria

- Hospital Diversion
- Scalable
- Sustainable
- Proven Past Initiative

Human Resources

- 1 FTE Nurse
- .5 FTE PSW
- 1 FTE Admin Coordinator/Scheduler

TBD re if resources already in place or need to recruit to support the initiative

Initiative Proposal Template

East Toronto Health Partners

Initiative Name

East Toronto CHC Network Outreach Flu Clinic Initiative

Initiative Description

Goal: Promote the importance and benefits of flu vaccination and increase the number of flu vaccines administered to target vulnerable populations in the East end of Toronto.
Objectives: Reduce the seasonal surge and its impact on hospital ER resources and staff. Leverage existing relationships to offer community flu shot clinics that target vulnerable populations in specific locations identified by/with partners (shelters, seniors TCHC buildings, retirement homes, and other local community agencies).
Statement of Need: As influenza can result in the hospitalization of any population, the focus will be on those less likely to access primary health services. The term vulnerable population will refer to seniors with chronic diseases, and people living in poverty.
Surge Category: Improve wellness and divert from hospital
Organization(s) Involved: South Riverdale CHC, East End CHC, Access Alliance, Flemingdon Health Centre/Health Access Thorncliffe Park
Key Principles and Evaluation Criteria: Leverage community relationships built in 2019-20 initiative to continue to run clinics and educate vulnerable populations on the benefits of immunization and conduct flu shot clinics. Share knowledgeable on the social determinants of health and how they further complicate individual wellbeing for members of vulnerable populations.

Outcomes and Measures

Outcomes

- Increase the # of vulnerable people able to access appropriate flu vaccinations
- Increase knowledge about the seasonal flu, vaccination and its benefits for vulnerable populations
- Decrease # of at-risk populations accessing ER services due to influenza related health problems
- Increase cross agency partnerships and pathways to better support vulnerable populations

Measures

- # of clinics
- # of flu shots administered
- # socio-demo graphic information collected related to flu vaccinations and vulnerable populations
- # of clients who would not have gotten the flu shot otherwise
- # of clients who received the flu shot for the first time

Existing Synergies/ Services

CHCs already offer flu shot clinics in the community but this is limited to available resources. One funding time would allow the network to offer more.
CHCs to build on existing relationships with local community partners to offer flu shot clinics and increase vaccination opportunities.

Budget Needed

Community Outreach Coordinator = $22,999.22
Registered Nurse = $12,579.19
Transportation costs = $3,000.00
Training, Admin Support & Project Management (in-kind)
Travel: $3,000
Clinical supplies = $2,000
Technology = $2520.00
Admin (15%) = $6,464.76
Total = $49,563.17

Human Resources

Community Outreach Coordinator= 1.0 FTE
RN = 0.6 FTE
Flu clinic team from last year has expressed an interest in continuing this work.

Initiative Proposal Template

East Toronto Health Partners

Initiative Name

Expand LTCH Clinical Supports

Initiative Description

COVID-19 has highlighted the need to appropriately support acute care access in LTCH settings. Through work completed over the past several months we have been able to identify strategies to better provide acute care in LTCH settings. This initiative would further spread that work among 10 LTCHs in East Toronto to enhance access to the existing Nurse Led Outreach Team (NLOT).
This strategy supports ED avoidance by providing care in place for vulnerable, high risk patients in LTC.

Outcomes and Measures

Decrease in ED visits for LTC residents

Improved access to acute care supports in LTC

Existing Synergies/ Services

Existing NLOT services
LTCH Supports in East Toronto

Budget Needed

$150,000
Staffing related expenses to support NLOT expansion through Winter Season

Human Resources

3.0 FTEs required

Initiative Proposal Template

East Toronto Health Partners

Initiative Name

Mobile Community IPAC Team

Initiative Description

Anticipating COVID-19 Wave 2 outbreaks, pre-empting outbreak management teams to support effective, timely outbreak management in LTCHs in East Toronto, we would like to proactively staff a team to provide these supports.
The Outbreak management teams include an Outbreak Support Lead and IPAC Practitioner support in a dedicated role.

Outcomes and Measures

Outbreak monitoring

Time to resolve outbreaks

Existing Synergies/ Services

Toronto Region LTC Supports

NLOT Supports

Budget Needed

$100,000
-Physician stipend for LTCH support
-IPAC Professional to support proactive assessments for LTCHs
-Outbreak management support

Human Resources

0.5 FTE IPAC required
1.0 FTE Outbreak Support

Initiative Proposal Template

East Toronto Health Partners

Initiative Name

Expanding Primary Care Clinics

Initiative Description

The economic impact of COVID-19 has resulted in closures of businesses, including primary care clinics in several neighborhoods in East Toronto. Prior to the pandemic, family practices in the Gerrard corridor and Crescent Town, were identified by the EasTFPN, as particularly needing supports to sustain capacity to serve a large numbers of patients (5000+) with complex care needs.. With the flu season upon us, and with the impact of the pandemic still palpable, this initiative will invest on key enablers to help sustain and increase capacity in primary care in these neighborhoods. Local physician engagement work, helped identify the following enablers, which are resources that are currently not available to the practices within the Gerrard corridor and Crescent Town (1) embedded IPC team members (such as RNs) (2) virtual care and EMR capabilities, and (3) MD funding models to reflect the complexity of services required by the patient populations served in this area.

Surge Category: improve wellness/divert from ED, addressing community health capacity

Organization(s) Involved: EasT-FP (representing solo physicians/FHGs, Crescent Town Clinic)

Existing Synergies/ Services

The EasTFPN has been working with the physicians in the Gerrard corridor, to address the impending HHR capacity issues (due to physician retirements), that are expected within the next year. The recent COVID19 pop-up clinic within the Crescent Town Clinic, has helped us deeply engage with the local physicians and understand the resources that are lacking, for primary care practices to serve the neighborhood. We will partner and engage with our ETHP to partner regarding nursing staff.

Budget Needed

Total: $165,000

- local HHR incentives for attaching patients left unattached by physician retirement in the Gerrard Corridor – Top Up – 44K
- EMR/virtual care investment - $30,000
- 1 FTE Registered Nurse - $91,000

Outcomes and Measures

Outcomes:

Increase HHR capacity in areas that require more primary care providers, based on gaps identified by the EasTFPN before and during the COVID pandemic.

Test of change, if successful, will support a business case to sustain and increase expansion of primary care, by supporting a the next steps towards increasing other primary care funding models in the East OHT (including more FHO and CHC MDs)

Measure Success:

influenza vaccines given/COVID tests done

% increase in service provider interactions attributed to having new physicians and IPC team members in the neighborhood

# of patients attached to ongoing primary care from practices of physicians that have recently retired, or are set to retire.

# of physicians recruited to increase the scope of their practice, to include patients from Crescent Town and the Gerrard corridor

Human Resources

- 1.0 FTE RN shared between sites
- Family physicians to assist and possibly join (longer term) specific high needs areas – incentive based approach

Initiative Proposal Template

East Toronto Health Partners

Initiative Name

SCOPE Mental Health Pathways 2020-21

Initiative Description

This is a continuation /expansion of the SCOPE Mental Health Pathways initiated in 2019-20 and evaluated as a success (which recommended to fund on a full year basis). Available to patients of SCOPE family practices (primarily on an after hours basis (community) and Hospital regular hours) it provides for rapid access to urgent psychotherapy, counselling, and connection to longer-term supports. It is expected that the impacts of COVID-19 on the targeted Year one populations will further reinforce the necessity of the program. **Participants**: Primary Care Practices, MGH and Community Organizations (Health/Social). Evaluation Criteria: Hospital Diversion from the ED, Mitigates COVID-19 impacts, Proven past Initiative Requiring Ongoing Funding

Outcomes and Measures

Increase access to mental health supports i.e. psychotherapy and counselling services to adults and seniors.
Success Measurement:

1. Number of referral
2. Number of consulting /psychotherapy
3. Qualitative patient experience
4. Days from referral to appointment
5. # of clients served by the program

Existing Synergies/ Services

Leverages the existing SCOPE platform and adds a connection to the new SCOPE service (MGH psychiatry expertise). Further Connects primary care to acute and community (Health and Social Services) in an organized sustainable fashion targeting year 1 populations and actively supports Primary Care Practices

Budget Needed

Project Expense: $106,000 based on 7 months implementation and 1 month to organize and bring on staff

In-Kind Services – PM supports via EasT-FPN (based on Bridge funding approval)

Human Resources

1.0 FTE Social Worker at MGH - regular hours
1.0 FTE Social Worker Community – after hours (multiple sites)
Pscyh Sessional Fees (consults to SWs)
Clinical Leadership
Mix of new hire and existing staff

Initiative Proposal Template

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Initiative Name

Community Hub and NCT Expansion

Initiative Description

Description: Building on the synergies of the Community Hubs'n'Mums and NCT strategies established during OHT year 1 and COVID19 wave 1, this initiative will provide additional resources such as 1 NP, project management, allied health, to target vulnerable patient populations in identified high needs areas (served by existing IPC teams; Oakridge + Taylor Massey, and or other priority neighbourhoods/locations such as Crescent Town, Blake Jones, 10 Glen Everest, 5 Wakunda Place). Priority clients will be determined in consultation with community and homecare partners , based on population needs and capability of existing local supports. During surge, the goal would be to ensure that residents are accessing flu shots, attaching to/receiving primary care and connecting to/receiving community supports .
Needs: Wave 1 of COVID-19 has amplified the need for integrated care for vulnerable populations specifically; the upcoming flu season with possible COVID-19 wave 2 will cause repeated disruptions to access to primary care and social services, and challenges to standard influenza clinics at the family doctor's due to PPE shortages. **Evaluation Criteria –** Hospital Diversion, Mitigates COVID-19 impacts, moves the system towards a sustainable design. **Key Principals:** Priority Neighbourhoods, Inter-Organizational Partnerships, Optimize Resource Sharing and Synergies. **Participating Organizations**: Hubs'n'MUMs NCT lead organizations plus applicable local partners dependent on priority neighbourhood/location finalization

Outcomes and Measures

Increase in the rate of flu shots within identified communities, connections to primary care (residents and establishment of local partnerships between community providers and primary care practices) referrals and receipt of appropriate community services for residents.

Measuring the success of the initiative: TBD – dependent on final program design and consultation with partners but anticipated as follows:
clients identified as high risk across all partners within selected sites; percentage of influenza vaccination offered/provided to all high risk clients; # connections made to primary/social/homecare services;

Existing Synergies/ Services

Leverage the Hubs'n'MUM NCT work already taking place, utilize local knowledge and capabilities (ie existing IPC teams or a strong local footprint) to build rapid capacity. Continue driving forward the strong integration of community services including Home and Community Care, with Primary Care. Potentially add capacity to existing house calls teams/ MUMs by adding NP who can roster unattached high risk homebound elderly. Align the organizational knowledge established through the pop-up CACs in vulnerable neighborhoods to align COVID19 outbreaks with flu-assessment centres, if needed, well-equipped with PPE.

Budget Needed

Funding needed: $200K

Leverage existing Hubs'n'MUMs/NCT/SETFHT/ HATP/CCAC/CHCs in kind supports, including project resources, executive sponsorship, possible space utilization, linkages to existing programs and services (clinical and or admin support) dependent on site location and delivery mechanism, in-kind support by Grant Dr Pham by OMA-MOH for on-call physician stipends and "Piroutte" shared trial electronic record across HUBS.

Human Resources

Team composition TBD but anticipated to consist of possibly select resources (for illustrative purposes): NP, Social Worker, RN, coordinator, mental health worker and engagement specialist. The complement will be determined with partners.

Engagement resources (physician and community) currently available with staff resources TBD.

Initiative Proposal Template

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Initiative Name

Mobile Phone Strategy

Initiative Description

COVID-19 has highlighted inequities in patient populations, and a fundamental gap is access for particular populations to a cell phone for connection to care.

By providing patients with a cell phone who cannot currently access one contributes to supporting hospital avoidance strategies.

Outcomes and Measures

Access to follow-up care

Decrease in repeat Emergency Department visits

Existing Synergies/ Services

Connection to primary care
Support from CHCs

Budget Needed

$25,000
To support purchase of cell phones and 3-6 months of telephone access

Human Resources

No FTEs required

Initiative Proposal Template

East Toronto Health Partners

Initiative Name

Community NICE Fund

Initiative Description

Goals and Objectives Fund one-time or time limited supports for the target population to

- Facilitate discharges from ED or acute care
- Prevent unnecessarily visits to hospital or returns to hospital

Target population is: frail individuals, vulnerable seniors, caregivers, people with mental-health, substance-use concerns and/or dual diagnosis likely to require hospitalization without this support.

Statement of Need Discharges from hospital can be delayed or visits precipitated by lack of necessities such as food, medication, hygiene products, clothing, mattress, mobility aids, housing security or needed services such as decluttering, extreme cleaning, bed bug treatment, personal care, falls prevention, transportation, MOW, adult day program, access to government income.

Surge Category Improve Wellness & Divert from hospital, Reduce Time in ED & Avoid Admissions and Transition Home Effectively

Organizations WoodGreen leading. Hospital and other community partners to identify clients in need of access to NICE fund and/or provide needed supports.

Key Principles Reduces Hallway Health Care, Targets year 1 seniors and adults MHA populations, builds inter-organizational partnerships and optimizes resource sharing and synergies

Outcomes and Measures

Outcomes

- Improve client experience of care
- Reduce 30 day hospital readmissions
- Reduce unnecessary hospital admissions
- Reduce unnecessary ED visits
- Reduce length of stay

Data to be tracked

- Client satisfaction with support received
- # of clients served
- # of clients transitioned from hospital
- # of clients where hospital staff perceived a length of stay reduction
- # of clients served requiring a 30 day hospital readmission
- Complexity of clients served
- Provider perception of # of clients where an unnecessary trip to hospital was avoided
- # of and types of interventions funded

Existing Synergies/ Services

- Build on existing capacity of the Virtual Hub, Seniors Help Line and WoodGreen's Social Workers and Assisted Living staff to provide supports and services that can effectively facilitate hospital discharges and prevent unnecessary hospital use or return
- Build on relationship with hospital to better support transitions and prevent unnecessary hospital visits

Budget Needed

- $50,000 needed to support the initiative
- In-kind supports include WoodGreen staff identification and support of the population that would benefit

Evaluation Criteria

- Hospital Diversion
- Reduces Time in ED
- Scalable
- Sustainable

Human Resources

.2 FTE Admin Coordination

Initiative Proposal Template

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Initiative Name

Emergency Department Virtual Assessments for LTCH / Shelters

Initiative Description

Currently there is not any way to access Physician assessments after hours for LTCHs or Shelters in East Toronto – this often results in the need to transfer patients to hospital for care.
The idea would be to pilot a model where clinicians/staff in LTCH or Shelters would be able to access ED Physicians after hours for direct consultations.

Outcomes and Measures

Decrease in ED visits for LTC / Shelter residents

Improved access to acute care supports in LTC / Shelters

Existing Synergies/ Services

Existing Virtual Care follow-up supports in ED
NLOT Supports for Virtual Care follow-up

Budget Needed

$25,000
To support purchase of virtual connectivity equipment;
Consider small stipend to support access to clinicians after hours

Human Resources

No FTEs required

Initiative Proposal Template

East Toronto Health Partners

Initiative Name

Virtual Hub for Transitional Care Coordination

Initiative Description

Goals and Objectives Provide hospital with single channel referral process for patients with complex health needs who require improved coordination of care and system navigation that connects them to a transitional care coordinator (TCC) who can provide intensive case management. Ensure that patients who are unattached or poorly attached are well connected to primary care. Support patient in the community to ensure needs are met and that the circle of care is connected – build a virtual team of care as needed from across sectors such as primary care, CSS, CMHA, HCC, pharmacy, housing etc.

Statement of Need Some patients with complex health needs do not have the support and coordination in place that is required to ensure a successful transition from hospital to community or ability to thrive in the community. This may include patient's need to be warmly connected to discharge plan referrals and services, need for identification of further missing services and/or need to connect those in the circle of care to ensure shared planning based on patient's goal for care.

Surge Category Improve Wellness & Divert from hospital, Reduce Time in ED & Avoid Admissions and Transition Home Effectively

Organizations WoodGreen leading with Cota and TC LHIN HCC as key partners. Hospital to identify patients who would benefit from connection to a TCC

Key Principles Reduces Hallway Health Care, Targets year 1 seniors and adult MHA populations, builds inter-organizational partnerships and optimizes resource sharing and synergies

Existing Synergies/ Services

- Build on existing capacity of the Virtual Hub partners, WoodGreen, Cota and TC LHIN HCC, to collaboratively provide transitional care coordination
- Build on relationship with hospital to better identify patients who would benefit to support transitions and prevent unnecessary access or returns

Budget Needed

- $40K to support the initiative
- In-kind WoodGreen, Cota and TC LHIN HCC transitional care coordinators

Outcomes and Measures

Outcomes

- Improve patient experience of care
- Improve coordination of care for patients with complex needs
- Connect patient's circle of care and develop a coordinated plan of care
- Reduce 30 day hospital readmissions
- Improve attachment to primary care

Data to be tracked

- Patient satisfaction with support received
- # of patients served
- # of patients transitioned from hospital
- # of patients where a coordinated plan of care is developed
- Complexity of patients served
- # of new services put in place
- # of patients who are connected to PCP
- # of patients connected to long-term care coordination/case management
- # of patients served requiring a 30 day hospital readmission

Evaluation Criteria

- Hospital Diversion
- Reduces Time in ED
- Scalable
- Sustainable

Human Resources

- .5 FTE Project Management
- .5 FTE Admin Coordination

Initiative Proposal Template

East Toronto Health Partners

Initiative Name

Psychogeriatric Hospital-Community Pathways

Initiative Description

Goals and Objectives Provide enhanced hospital to community pathways for psychogeriatric patients to help facilitate discharges from ED or acute care and to reduce unnecessarily visits to hospital or returns to hospital.
Statement of Need The population of seniors coming to hospital with psychogeriatric issues often require support to effectively transition to the community due to high likelihood of struggling with follow-up and follow-through. This population is also typically overrepresented in the ALC population and would ideally be better served in the community when possible.
Surge Category Reduce Time in ED & Avoid Admissions, Transition Home Effectively and Improve Wellness & Divert from Hospital
Organizations Michael Garron Hospital and WoodGreen. Others?
Key Principles Reduces hallway health care, targets year 1 seniors, builds inter-organizational partnerships and optimizes resource sharing and synergies

Existing Synergies/ Services

- Build on existing capacity of the Virtual Hub, Crisis Outreach for Seniors Service (COSS) and of other community based services to support this population
- Build on Virtual Hub relationships with MGH GEM nurses and Virtual Ward staff
- Enhance existing hospital to community relationship to further support transitions and prevent unnecessary hospital visits

Budget Needed

- $50K needed to support the initiative
- In-kind supports include existing WoodGreen transitional care coordinator (TCC) capacity

Outcomes and Measures

Outcomes
- Improve client experience of care
- Improve coordination of care for patients with complex needs
- Reduce length of stay
- Reduce unnecessary hospital admissions
- Reduce 30 day hospital readmissions
- Reduce unnecessary ED visits

Data to be tracked
- Client satisfaction with support received
- # of clients served
- # of clients transitioned from hospital
- # of clients where hospital staff perceived a length of stay reduction
- # of clients served requiring a 30 day hospital readmission
- Complexity of clients served

Evaluation Criteria

- Hospital Diversion
- Reduces Time in ED
- Scalable
- Sustainable

Human Resources

- 1 FTE Transitional Care Coordinator
- TBD