



**East Toronto
Health Partners**

EasT-FPN
EAST TORONTO FAMILY PRACTICE NETWORK

Up on Digital OHT Update

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Practice Network (EasT-FPN)

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Family Practice Network (East-FPN)

Content



- Background on ETHP OHT
- How are we making integrated care happen?
- Examples of digital tools
- What's next?

The ETHP Journey



2015

- Toronto East Health Network was established accounting for all the work happening outside of the hospital walls



2019

- September: Creation of EastT-FPN
- December: EastT-FPN signing the OHT Joint Venture Agreement (JVA) and becoming part of ETHP.

2018

- East Toronto Health Partners (ETHP) was established as part of the first wave of OHTs in Ontario



2023

- ETHP is one of the 12 Accelerated OHTs
- 1 of the 7 OHT on the Leading Homecare Project



East Toronto Health Partners: Who We Are



Anchor Partners



Partners*



Network of patient, caregiver and community advisors and community health ambassadors

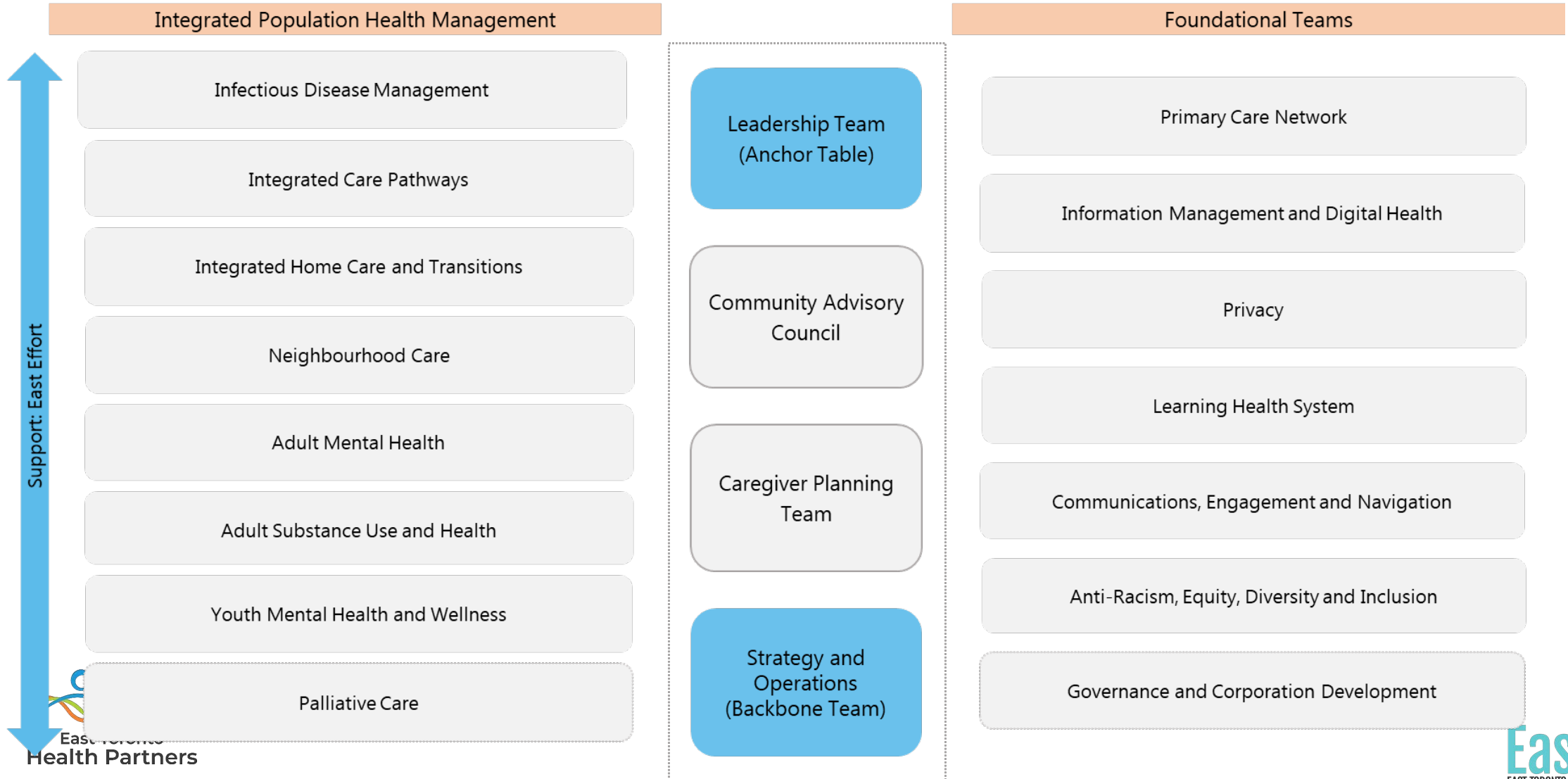


*See a full list of EHP member organizations at <http://ethp.ca/partner-organizations>

ETHP Governance



ETHP Portfolio Structure (revised Dec 2023)



Our Vision for Integrated Care Delivery



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

How are we getting there?

- *Right people* – building primary care capacity and connecting our organizations
- *Right solutions* – enabling teams to work together more efficiently via technology that works for our needs

People of ETHP



Community Leaders

- Co-Leads in governance
- CAC advisory sown into all levels of governance



Diverse Partnerships

- More than 100 community, primary care, home care, hospital and social services organizations



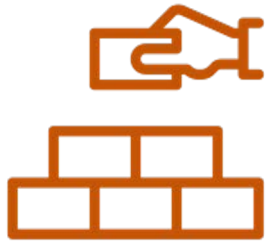
Primary Care Leadership

- East-FPN – the voice for over 200 primary care providers, practicing in East Toronto

ETHP Digital Priorities

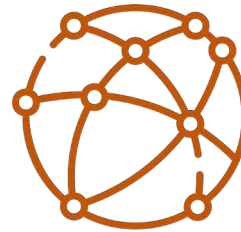


Our Digital team has a 2-year digital strategy designed to address the needs of the OHT



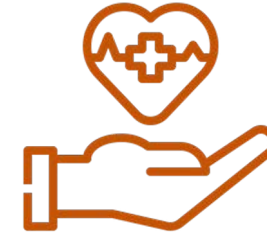
Business Transformation & Sustainability

- A. Develop a sustainable support model for ETHP partners around the use of common digital assets;
- B. Enable better adoption and utilization of the Microsoft platform across the OHT



Cross ETHP OHT Connectivity

- A. Improve digital navigation of services by patients and providers
- B. Enhance business to business communication channels



Enhanced Clinical Operations

- A. Create a Microsoft Collaboration Solution for cross ETHP OHT Collaboration and patient/client care delivery

Building the OHT Digital Infrastructure



- Developing solutions that are co-designed for our needs



Collaborate Care
Planning Tool



Shared
Document Library



Common
Communication Tool

- Scalability and sustainability underlie solution designs
- Share resource model in the works

Collaborate's Pilot Features

This custom Microsoft 365 solution for integrated patient/client care will provide access to:

- A secure platform for providing cross organizational coordinated care planning for ETHP patients/clients
- Document sharing (PHI permitted)
- Referral management
- Consent management
- Patient/client information sharing and care planning (PHI permitted)
- Video rounding/meetings
- Secure communication thread



Sample Client Profile



ETHP Collaborate
Try the new look

Save Save & Close Deactivate Assign Delete Refresh Check Access
Share

Jessica Richards - Saved

Client · ETHP Client - Admin

C00001134 Client ID

None Privacy Flag

To be clarified Client Status

Jennifer Andrews
Owner

Client Profile (CCP)
Capacity and Consent (CCP)
Well-being Factors (CCP-detailed)
Support (CCP)
Care Planning (CCP)
Uploaded Documents (CCP)
Related

First Name * Jessica

Preferred Name (if different from First Name) ---

Last Name * Richards

Date of Birth 10/18/2011

Age 12

Gender Identity To be clarified

Transgender Identity To be clarified

Pronouns To be clarified

Identity - Indigenous ---

Identity - Racial (to support population health planning) ---

ADDRESS (enter "no fixed address" on line 1 and your organization postal code if applicable)

Line 1 * no fixed address

Line 2 ---

Line 3 ---

City * ---

Postal Code * M1K0A4

Neighbourhood * Clairlea-Birchmount

Housing Type ---

Others Living in Household ---

[Get Directions](#)

Map is disabled for this organization.

CLIENT CONTACT INFORMATION

Client Email (include only if consent has been provided) ---

Client Phone Number * (enter "no phone" if applicable) ---

Preferred Method of Contact ---

Best Person to Contact ---

Best Time to Contact ---

Safe to leave voicemail To be clarified

Other ways to contact client ---

ALTERNATE CONTACT INFORMATION

Contact Name ---

LANGUAGE

Referrals

Cases

Rounds

Rounds Meetings

Help & Support

Support

Sample of Referrals in Collaborate



REF000001074 - Saved
Referral · Referral Form

Accepted Referral Status JA Jennifer Andrews Owner

General Details Related

Referral ID: REF000001074

Program: PCCRT

Referral Type: PCCRT 1

Discussion Urgency at Rounds: Semi-urgent (within a month)

Primary Reason for Referral (in addition to CCP creation): 2. Case management connection support

Submit Referral: Yes

Consent for PCCRT Referral

Client Consent: Yes – no restrictions (verbal only – to get signed cons)

Consent for Email Communication: No

Upload Consent Form: No file chosen

First Name: Joe

Preferred Name (if different from First Name): Jennifer

Last Name: Referral

Date of Birth: 7/31/1980

Address (enter "no fixed address" on line 1 and your organization postal code if applicable)

Line 1: 272 Chisholm Ave

Line 2: ---

Line 3: ---

City: Toronto

Postal Code: M1K0A4

Neighbourhood: Clairlea-Birchmount

Well-being Factors (CCP) - enter all known factors

Physical and Mental Health Factors

Factor ↑

Disabilities (Sensory)

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Social Factors

Factor ↑

No data available

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East Toronto-Family Practice Network



Connects primary care within the OHT



Serves as a vehicle for providing local primary care sector's voice in OHT decision-making



Supports OHT clinical change management & population health management approaches.

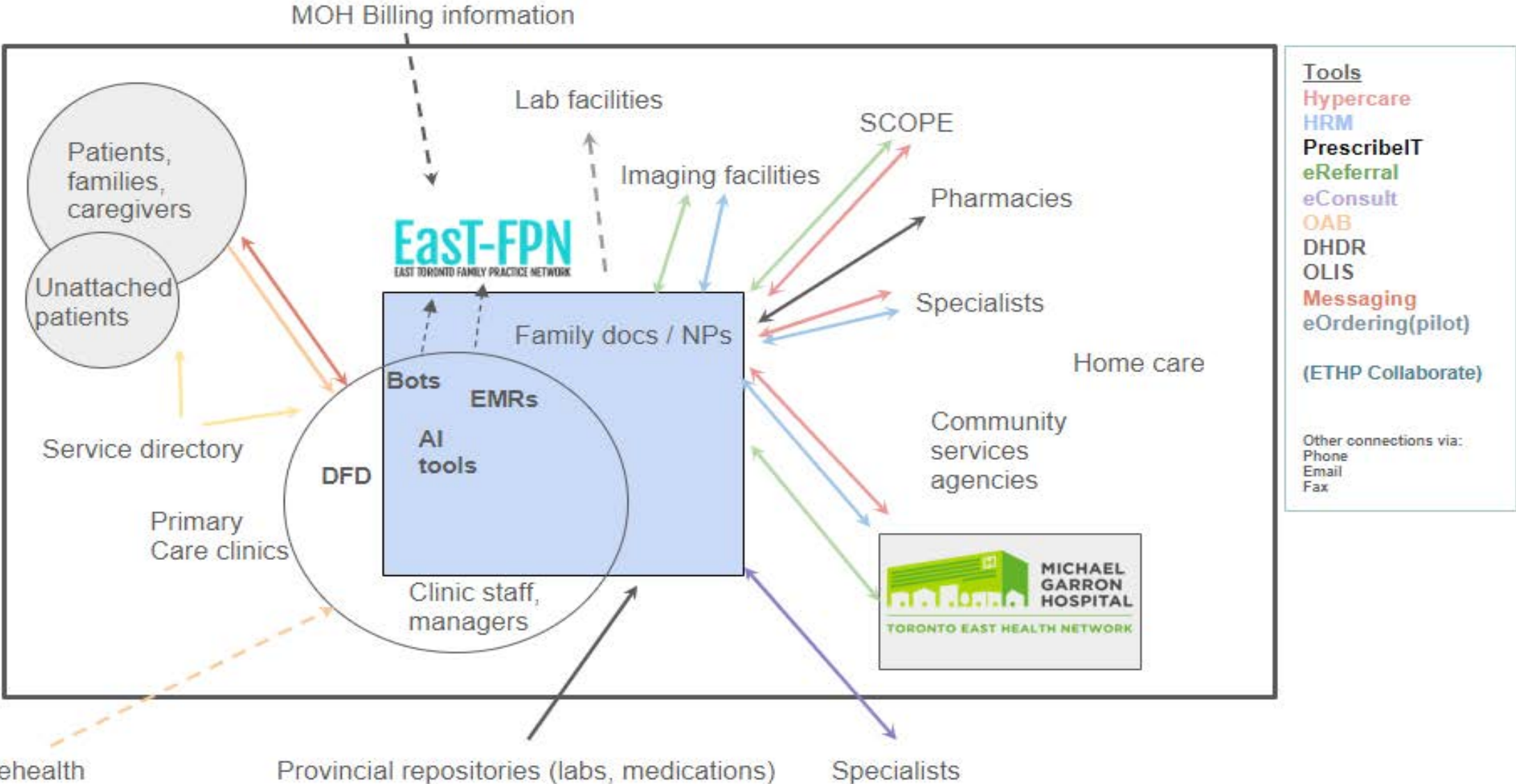


Support local primary care Health Human Resource planning within the OHT



Facilitates access to clinical & digital supports & improvements for primary care.

East-FPN Digital Tools, Connections & Data Flows



Digital Tools for Primary Care



HYPERCARE

- Real-time and timely communication around patient care
- Scaled early in the pandemic as a secure way to connect providers with specialists (besides fax, call & paging systems).
- Access to specialists and SCOPE program via the Nurse Navigator, leads to ED Diversions
- VISION: Secure messaging available to providers across all OHT organizations



POPPY BOT

- Population Health Management bot (developed by eCE) to identify patients overdue for cancer screening
- Increases efficiency of cancer screening work for primary care, beneficial to patients.
- VISION: Have similar bots running across primary care EMRs in our OHT, collate data, identify key trends, potential cases for intervention or referral to ICPs

DIGITAL FRONT DOOR

- Give patients & caregivers the necessary information at "first point of contact" with primary care; help them "get their task done".
- Initial deployment: Reduced inbound communications to overburdened family practices, increased accessibility of online booking
- VISION: Explore ways to deploy "Front Door experiences" more broadly across our OHT; Link "front doors" across different sites of care.

Where is ETHP going next?

What do we need to succeed?



Opportunities to enhance the OHT's capabilities and governance through incorporation and organizational maturation



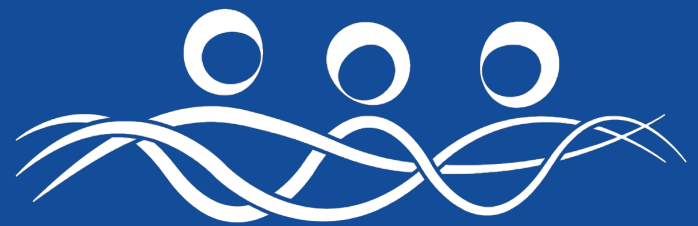
Build, scale and support digital solutions that enable OHTs via sustainable funding and alignment with local priorities



More incisive data to better inform the work we do related to digital transformation and population health



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Any Questions?



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Thank you

Presentation prepared by Alsanha Bhimani,
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and Tach Murray