Eastern York Region North Durham

EYRND ONTARIO HEALTH TEAM

2022-2023 ANNUAL REPORT

Elevating Excellence:

THE JOURNEY TOWARDS SEAMLESS CARE

CONNECTING CARE FOR CLIENTS, FAMILIES, AND CAREGIVERS | EYRND.ca

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Message from our Co-Chairs

As Co-Chairs of the Eastern York Region North Durham Ontario Health Team (EYRND OHT), we are pleased to present the annual report for the fiscal year 2022-2023. This report encapsulates our team's commitment, achievements, and ongoing dedication to improving health care delivery and outcomes for the residents of Markham, Stouffville, Uxbridge, and beyond.

Over the past year, EYRND OHT has made significant strides in fulfilling our mission to provide patient-centred coordinated care that is accessible, efficient, and of the highest quality. We have tackled various challenges head-on, working collaboratively with our partners and stakeholders to enhance the health and well-being of our community.

This past year...

- The Seniors Home Support program (SHS) successfully assessed 100 per cent of its patients within 14 days of hospital discharge, with home visits occurring at a median of three days and welcomed over 100 new patients to the program. SHS is an integrated primary care program delivered by an interdisciplinary team to home-bound seniors who for medical, social, or cognitive reasons cannot access office-based primary care services. SHS is one of Ontario's few home-based primary care programs with community paramedic integration
- Standardized 24/7 access and navigation model for the residents of EYRND OHT was planned with the goal to implement quality improvements to the current navigation process so that the caller can have a standardized experience no matter which organization (e.g., 211, Connex, Streamlined Access, etc.) is called. More importantly, callers can be linked with as few steps as possible to appropriate services that are able to meet their need(s)
- Central Region Virtual Urgent Care Clinic (VUCC) was launched in partnership with Oak Valley Health and Ontario Health. The VUCC uses a nurse practitioner (NP) led clinical model that is integrated with the bundle of services offered by the EYRND OHT, its local partners, and ultimately its regional partners. The VUCC provides episodic access to virtual care while offering thoughtful and comprehensive follow-up care
- Community Health Clinic (CHC) was launched in partnership with Oak Valley Health and Well Plus Compounding Pharmacy. The CHC provides quick access to care providers who specialize in paediatric care and is available to people aged six months and older

In this report, you will find more information about our successes and accomplishments. We extend our heartfelt gratitude to all our partners, health care providers, staff, and community members who have contributed to our achievements this year. Your dedication and tireless efforts have made a tangible difference in the lives of those we serve.

In this journey towards seamless care, we are excited about the opportunities and challenges that the future holds. Our commitment to continuous improvement and innovation remains unwavering as we work together to enhance health care services that truly meets the evolving needs of our community.

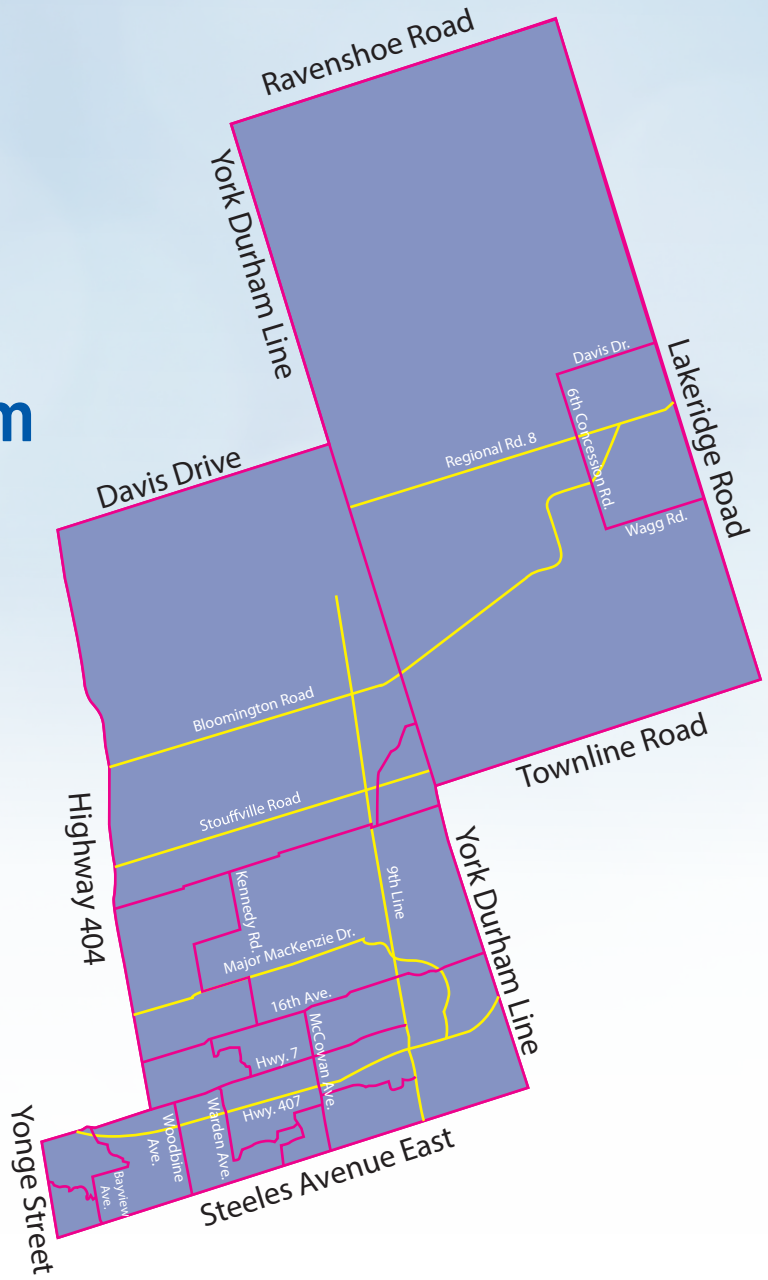
This annual report reflects the dedication of our entire team and serves as a testament to what can be achieved when we work collaboratively towards a common goal. We encourage you to review the report in detail and share your feedback with us.

Dr. Cristina Popa
Co-Chair, Core Leadership Council, EYRND OHT
Co-Chair, Primary Care Advisory Council, EYRND OHT

Alykhan Suleman
Interim Co-Chair, Core Leadership Council, EYRND OHT
Chief Executive Officer, Social Services Network

Overview of the Eastern York Region North Durham Ontario Health Team

The EYRND OHT was established in December 2019 with the mandate to facilitate and coordinate connected, seamless, people-centred care 24/7. The EYRND OHT serves the Township of Uxbridge, located within the Regional Municipality of Durham, the City of Markham, the Town of Whitchurch-Stouffville and the community of Thornhill, located within the Regional Municipality of York, as well as clients and families who use health and community-based services listed in areas above but live elsewhere.



Our partners:

360° kids

ADDICTION SERVICES CENTRAL ONTARIO

Alzheimer Society YORK REGION

Carefirst SENIORS & COMMUNITY SERVICES ASSOCIATION

CHATS Community & Home Assistance to Seniors

Entité 4 MD Engager • Collaborer • Réaliser

Markham Family Medicine Teaching Unit Health for All FAMILY HEALTH TEAM

Krasmancentre Inspiring Excellence in Peer Support One Connection at a Time

Markham FAMILY HEALTH TEAM

Oak Valley Health

Health

S·R·T· MedStaff

UNIONVILLE HOME SOCIETY

York Region

YSSN YOUR SUPPORT SERVICES NETWORK

Strategic plan

The 2021-2023 strategic plan aligned the strategic goals with the five priority areas in the Population Health Management and Equity Plan, also known as the Ontario Health Team (OHT) plan submitted to the Ministry of Health (MOH) in July 2022. This OHT plan serves as a practical guide on how OHTs will fulfill their obligations outlined in the transfer payment agreements within the five designated priority areas. Additionally, it outlines their broader strategy for advancing the OHT throughout the duration of the agreement. Under this strategic plan, EYRND OHT oversaw 19 active projects over 13 funding envelops.

OHTs are revolutionizing the health care system by structuring and providing care that is closely integrated with patients and their respective communities. Under the OHT model, health care providers collaborate as a unified team, irrespective of their care location, simplifying the process for patients to navigate the system and transition smoothly between different providers and health care settings.

As the current strategic plan came to an end on March 31, 2023, EYRND OHT held several visioning sessions between May to September 2023, to create the 2023-2026 strategic plan based on the guiding principles. Here, we present the overarching strategy of the EYRND OHT, which places a strong emphasis on elevating patient-centred care throughout the entire spectrum of health care services. Our strategy is intricately aligned with the Ministry of Health's Path Forward, all the while taking into account the distinct priorities of our local community.

MISSION:

Our commitment is to establish a person-centred culture and create an improved coordinated access health care model for clients, families, caregives, and service providers.

We are aiming to achieve this by supporting the five objectives of the Provincial Quintuple Aim:

- Enhance patient and caregiver experience
- Improve patient outcomes and population health
- Enhance provider experience
- Improve value
- Advance health equity

VISION:

Our vision is to improve the health of the communities we serve and foster an improved individual and provider experience

Our strategic plan encompasses six goals, each contributing to our mission:

Primary care integration: Fostering seamless collaboration among primary care providers to enhance patient experiences and outcomes.

Seamless transitions & integrated care: Ensuring smooth transitions between different stages of care, through integration, leading to comprehensive and cohesive health care.

Reduce health inequities: Addressing disparities in health care access and outcomes to create a more equitable system.

Community empowerment: Engaging and empowering our community to actively participate in their own health care decisions and well-being through education and awareness of OHT and services offered in community.

Patient & provider navigation: Facilitating navigation through the health care system for patients and providers alike, ensuring efficient access to services.

OHT maturity: Fostering OHT growth through governance, strategic partnerships, continuous evaluation and innovation.

The formulation of this strategy was a collaborative endeavour, with input gathered from a diverse range of stakeholders, representing various sectors. This inclusive approach equips us to better meet the health care needs of our community while remaining in harmony with provincial health care objectives. Together, we are committed to advancing health care excellence and patient-centric services.

OHT OVERARCHING STRATEGIC PLAN

QUINTUPLE AIM

Enhance patient and caregiver experience
Improve patient outcomes and population health
Enhance provider experience
Improve value
Advance health equity

MINISTRY OF HEALTH cQIP INDICATORS

Improve overall access to care in the most appropriate setting

1. INDICATOR. Alternate Level of Care Days

Increase overall access to community mental health and addictions (MHA) services

2. INDICATOR. Rate of emergency department visits as first point of contact for MHA-related car

Increase overall access to preventative care

3. INDICATOR. Percentage of screen-eligible patients up-to-date with Papanicolaou (Pap) tests

4. INDICATOR. Percentage of screen-eligible patients up-to-date with mammogram

5. INDICATOR. Percentage of screen-eligible patients up-to-date with colorectal screening

EYRND OHT GOALS

GOAL 1. Primary care integration
GOAL 2. Seamless transitions and integrated care
GOAL 3. Reduce health inequities
GOAL 4. Community empowerment
GOAL 5. Patient and provider navigation
GOAL 6. OHT maturity

ENABLERS

Collaborations
Communications
Digital tools
Health system users
Privacy (Data Sharing Agreement)

Financial

In FY2022-2023, $750,000 was the implementation funding from the MOH.

In FY2022-2023, $750,000 was spent with 90 per cent on service delivery implementation and project management, and the rest on, physician, patient, and caregiver engagement.

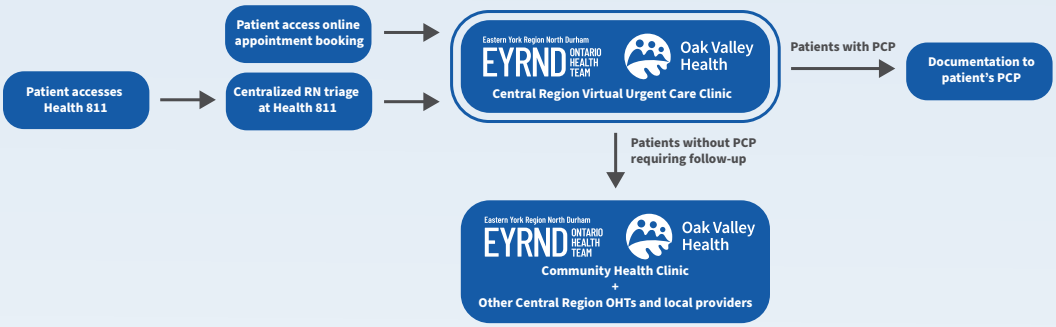
Contribution from our partners included in-kind support on project management, expertise in data analysis, financial monitoring, and program evaluation.

Throughout the last three years, the EYRND OHT implemented the following key initiatives in alignment with our overarching strategic plan.

EMERGING FRONTIERS: ACCESS TO PRIMARY CARE

INITIATIVE: Central Region Virtual Urgent Care Clinic

- Launched on July 1, 2023
- The Central Region Virtual Urgent Care Clinic is available for those who require timely access to care for urgent, non-life-threatening conditions that can be addressed virtually
- This nurse practitioner led clinic model is integrated with the bundle of services offered by the EYRND OHT, its partners, and ultimately its regional partners
- Operates seven days a week from 1:00 to 9:00 p.m.



Participating organizations:
Oak Valley Health
Ontario Health Central Region

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance patient and caregiver experience
- Improve patient outcomes and population health
- Improve value
- Advance health equity

cQIP

- Increase overall access to preventative care

OHT Goals

- Seamless transitions & integrated care

INITIATIVE: Community Health Clinic

- In partnership with EYRND OHT and Oak Valley Health, the Community Health Clinic (CHC) opened on May 15, 2023, serving the patient population of Markham, Stouffville, and surrounding areas
- Staffed by nurse practitioners (NPs), the CHC serves as the gateway for health care for everyone aged six months and older, from initial appointment, to follow ups, and referrals as needed. The clinic provides quick access to care
- The CHC has streams for adult care as well as children's rapid access clinic
- The clinic provides primary as well as episodic care to ensure patients do not have to use the emergency department as their point of access
- CHC is located inside Well Plus Compounding Pharmacy at 5402 Main St, Unit 5, Stouffville. CHC operating hours are Monday through Friday from 9:00 a.m. to 4:00 p.m.

Services offered:

Symptoms and conditions that can be accessed and treated at the clinic include:

- Acute respiratory tract infections
- Ear aches
- Wounds and skin infections (e.g., cellulitis)
- Newborn care
- Abscesses
- Sexually transmitted infections (STIs)
- Urinary tract infections (UTIs)
- Skin ailments
- Gastroenteritis
- Chronic conditions including hypertension, congestive heart failure (CHF), diabetes, chronic obstructive pulmonary disease (COPD)
- Cancer screening – to arrange PAP smear, colonoscopy, or mammogram
- Prescription renewals
- Work-related assessments and notes
- Pregnancy testing

Participating organizations:

Oak Valley Health

Well Plus Compounding Pharmacy

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance patient and caregiver experience
- Improve patient outcomes and population health
- Improve value
- Advance health equity

cQIP

- Increase overall access to preventative care

OHT Goals

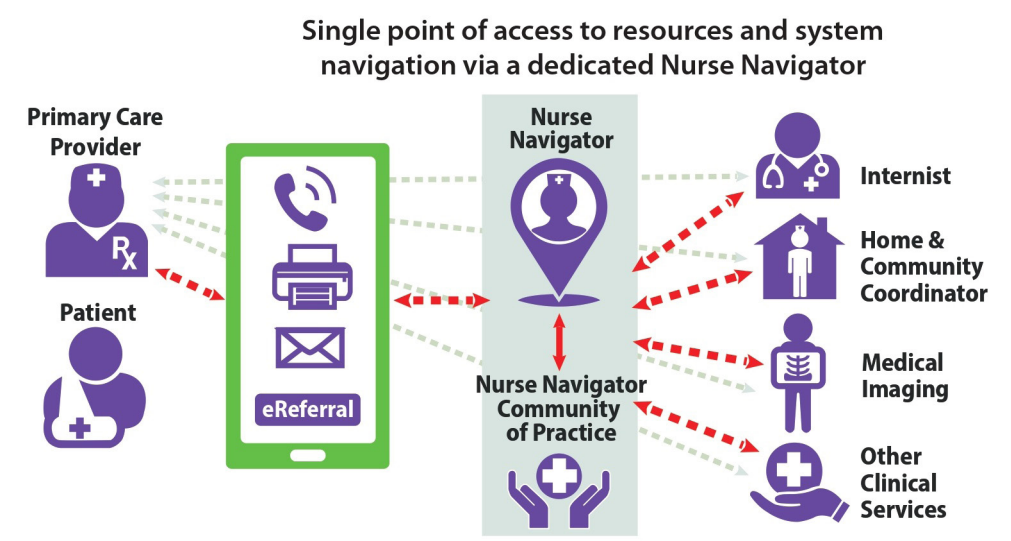
- Primary care integration
- Seamless transitions & integrated care
- Reduce health inequities
- Patient & provider navigation

NAVIGATION AND CARE INTEGRATION

INITIATIVE: SCOPE

- SCOPE supports primary care providers by improving equity and access to care for their patients in the EYRND OHT communities
- As a single point of contact, a nurse navigator connects and navigates primary care providers to a multitude of services for their patients in an efficient and timely manner
- Services include urgent consultations, diagnostic imaging, curated home and community care, mental health, and navigating other services available in acute care or in the community
- Launched in April 2022, SCOPE started with just over 35 physicians. As of March 31, 2023, SCOPE had onboarded 128 physicians and completed 721 total number of nurse navigator calls
- The initiative comprehensively addresses patient, caregiver, and provider experience, and improves population health outcomes, value, and efficiency

SCOPE
A virtual team for primary care providers



16 SCOPE sites in the province, connected community of practice shares knowledge, resources and facilitates cross-regional navigation

Participating organizations:
Oak Valley Health
Women's College Hospital

Primary care lead:
Dr. Cristina Popa

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance patient, caregiver, and provider experience
- Improve patient outcomes and population health
- Improve value
- Advance health equity

cQIP

- Increase overall access to preventative care

OHT Goals

- Patient & provider navigation

INITIATIVE: Access and Navigation

- Successful implementation of phase 1 on March 31, 2023, a consistent model for navigation calls to The Regional Municipality of York, ConnexOntario, Findhelp - 211, Home and Community Care Support Services Central and Central East
- An improved process for the navigators of the participating organizations that will link callers seamlessly to appropriate services that meet their needs and provide a standardized experience regardless of which navigating organization is contacted
- Scope expanded on July 1, 2023, to include callers within the Southlake Community and Western York Region (WYR) OHT attributed populations. In phase 2, additional service provider organizations will be added as partners to the project
- Evaluation of the model to understand gaps in service needs and impact of improvements is underway
- Work continues with Ontario Health to ensure integration of local navigation services with the Health811 initiative

Participating organizations:
Addiction Services Central Ontario
Central and Central East Healthline
ConnexOntario
Findhelp - 211
Home and Community Care Support Services Central East Region
Home and Community Care Support Services Central Region
The Regional Municipality of York
Your Support Services Network - Streamlined Access

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance patient, caregiver, and provider experience

cQIP

- Increase overall access to community mental health and addiction services

OHT Goals

- Patient & provider navigation

INITIATIVE: Streamlined Access

- Streamlined Access is York Region's mature, localized solution to coordinated access to Mental Health and Addictions (MHA) services. Streamlined Access provides access and navigation to 26 plus individualized programs which can be categorized into three "baskets of services", mental health case management, mental health supportive housing, and assertive community treatment teams
- Over the last two years, Streamlined Access Primary Care Pathway has been implemented in EYRND OHT. The goals of this initiative are:
    - To improve health care provider experience by reducing the burden on primary care providers through establishing a single, integrated, and coordinated point of access for mental health and addictions referrals
    - To ensure the sustainability of mental health and addiction referrals for ages 16 and older from primary care providers
    - To provide navigation support for referrals and navigation for EYRND OHT and primary care providers
    - Total of 133 primary care referrals were received since the launch of the initiative
- Next phase (phase 3) of this initiative includes combining both projects that include Regional Youth OHT project and Streamlined Access expanding the Streamlined Access Primary Care Pathway to Southlake Community and Western York Region OHTs. This phase also includes the implementation of the e-Referral platform called Oceans with EYRND OHT

Participating organizations:
Addiction Services Central Ontario
Canadian Mental Health Association - York Region & South Simcoe
Hong Fook Centre
Krasman Centre
LOFT Community Services
Oak Valley Health
Southlake Community OHT
Western York Region OHT
York Support Services Network

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance patient, caregiver, and provider experience
- Improve patient outcomes and population health

cQIP

- Increase overall access to community mental health and addiction services

OHT Goals

- Reduce health inequities

INITIATIVE: First Link

- First Link® is a direct referral program that connects newly diagnosed persons with dementia and their caregivers with community supports, including:
    - 170 referrals were received by the First Link program as of March 31, 2023
    - Learning supports – dementia education regarding day-to-day living, communication, positive approaches to care, strategies for managing challenges, and preparing for the future
    - Link to care services – connection to Alzheimer Society programs and navigation of other community resources including recreation programs, vulnerable person registry, in-home care, meals-on-wheels, transportation, adult day programs, and more
    - Supports – social work services and facilitated peer support groups

Participating organizations:
Alzheimer Sociey of York Region

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance patient and caregiver experience
- Improve patient outcomes and population health
- Improve value
- Advance health equity

cQIP

- Increase overall access to community mental health and addiction services

OHT Goals

- Reduce health inequities

INITIATIVE: Mobile Diabetes Foot Care Clinic

- The clinic offers treatment to people living with diabetes registered through one of the partner Diabetes Education Clinics, with a focus on providing care for those with financial difficulties, no extended health benefits, transportation and mobility issues, cognitive and physical impairment, issues with activities of daily living/basic self-care, diabetes neuropathy, diabetes nephropathy, and diabetes retinopathy
- It also helps patients struggling to travel to stationary clinics throughout northern York Region, Southern Simcoe County, and Georgina Island
- Goal is to avoid hospital emergency visits and amputations
- This delivery method and monitoring for high-risk patients provides access and equity to those patients who have traditionally been underserved, hence suffer more serious complications
- Project was successfully launched in May 2023

Participating organizations:
CareFirst Seniors and Community Services Association
Humber River Hospital
Mackenzie Health
North York Family Health Team
North York General
Oak Valley Health
SE Health
Southlake Regional Health Centre
Vaughan Community Health Centre

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance patient and caregiver experience
- Improve patient outcomes and population health
- Improve value
- Advance health equity

cQIP

- Increase overall access to preventative care

OHT Goals

- Reduce health inequities

TRANSITION AND HOME CARE SERVICES

INITIATIVE: Seniors Home Support Program

- Seniors Home Support (SHS) program is an integrated primary care program delivered by an interdisciplinary team to home-bound seniors who for medical, social or cognitive reasons cannot access office-based primary care services, and one of Ontario's few home-based primary care programs with community paramedic integration
- Referrals are accepted from any source, breaking down barriers to access
- SHS program providers meet bi-weekly for inter-professional rounds where, among other tools, a shared electronic record (EMR) is used to collaborate on complex cases
- Patients have access to an interdisciplinary team to support quality of life, medication safety, caregiver support and foot care. Patients have routine virtual and home visits by their primary care provider and have additional support of a nurse navigator, nurse practitioner, and community paramedics for urgent issues
- The hospital-based nurse navigator fosters direct communication with Oak Valley Health's inpatient team, patient flow coordinators, and families. SHS offers home palliative care for enrolled patients as appropriate, supporting continuity of care and aging in place
- Since launch of the program in June 2021, 100 per cent of SHS patients are being assessed within 14 days of hospital discharge, with home visits occurring at a median of three days and patients are seen same or next day when an urgent home visit is requested
- Over the last fiscal year 2022-2023, SHS welcomed 127 new patients to the program, and increased its capacity from 120 to 205 active patients with addition of a second physician, Dr. Annie Cheung. The program has served a total of 291 patients to date
- Between June 1, 2021 to March 31, 2023, SHS has supported 39 palliative home deaths through close collaboration with community nurses. Of 75 total deaths, 96 per cent of caregivers felt that the patient died in the preferred location of care
- The SHS program strives to provide goal congruent care, by ensuring 100 per cent of patients have a documented advance care plan, while also revisiting goals of care regularly
- There continues to be high demand for the SHS program. A major focus of the 2023-2024 year is addition of a third physician to address the waiting list of 30+ patients

Participating organizations:
Home and Community Care Support Services - Central Region
Markham Family Health Team
Oak Valley Health
Unionville Home Society (South East Geriatric Outreach Team) - June 2021- Dec 2022
York Region Paramedic Services - Community Paramedicine Program

Primary care program lead:
Dr. Elizabeth Mui

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance patient and caregiver experience
- Improve patient outcomes and population health
- Improve value
- Advance health equity

cQIP

- Improve overall access to care in the most appropriate setting

OHT Goals

- Reduce health inequities

INITIATIVE: Integrated Transitional Care Program: Care@Home, Care@Home+

A one care team approach to discharge complex patients from acute care setting to the most suitable destination (patients' home, long-term care, retirement home) through newly formed partnerships including a hospital, home care, and community support services.

Care@home

- Up to sixteen-week transitional care program of in-home services upon hospital discharge in collaboration with SE Health, CHATs, and ProResp
- Goal is to make transition home as stress-free and smooth as possible and to help patient recover and become more independent while avoiding readmission to hospital

Care@home+

- Wrap around services at home to individuals with complex needs who are mostly living in the community, as means to minimize avoidable emergency department (ED) visits or hospital admissions and to improve patients' health outcomes and experience. These services are provided in partnership with South East Geriatric Outreach Team, LOFT (IPOP and Behavioural Support Services), CHATS, and SE Health

Transitional Care Units

- Transitional care units are located at retirement homes for patients who no longer need acute level of care, but require on-going support to meet their health care needs before they are independent enough to return home. An interdisciplinary team is available at the transitional care units to provide the appropriate level of care
- Support is provided until patients' goal(s) have been met and the condition is stable

Participating organizations:

Bayshore HealthCare
Community & Home Assistance to Seniors (CHATS)
Geriatric Outreach Team
LOFT Community Services
Oak Valley Health
ProResp Inc.
SE Health

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance patient and caregiver experience
- Improve patient outcomes and population health
- Improve value

cQIP

- Improve overall access to care in the most appropriate setting

OHT Goals

- Seamless transitions & integrated care

DIGITAL HEALTH

INITIATIVE: Early Warning Network (EWN)

- Funded through the Ministry of Health and Ontario Health, the Early Warning Network (EWN) project is a multi-faceted initiative that encompasses acute, and long-term care (LTC) settings, utilizing resident/patient condition data to drive informed decision-making and early discussions regarding care transitions, bed utilization, resident/patient flow, admissions, and more. The ultimate objective of the EWN is to enhance timely identification of patients and residents experiencing health deterioration, enabling efficient intervention in the most appropriate setting
- In 2022-2023 phase 1, an EWN prototype was successfully developed for LTCs and the solution was customized for an acute care setting
- Key success strategies revolved around co-design and evaluation. To ensure effectiveness, LTCs and acute care partners were engaged through co-design sessions, fostering collaboration and insights. Diverse evaluation methods gathered feedback for solution refinement, aligning with evolving stakeholder needs
- Furthermore, the solution was tailored to the partners' diverse needs. Each partner's unique requirements were considered through engagements to create customized solutions that were highly effective and relevant
- Phase 1 user acceptance testing was conducted with both administration and frontline staff. Overall, the responses were positive, key highlights included:
    - Easy to navigate, enable earlier interventions and better visibility for required follow-ups
    - LTCs clinical and administration leaders could see the potential to leverage data on residents, that might lead to quicker response for follow-ups, and ultimately perhaps reduced need for transfer to an ED
    - Significantly reduces the elapsed time between taking vitals to electronic medical record entry for acute care staff, thereby supporting timely identification of patient health deterioration
- Future visions of health system level impacts include:
    - Connected frontline providers, streamlined workflow and improved efficiency
    - Data-driven analytics and reporting
    - Enhanced resident/patient outcome
    - Cost avoidance and resource allocation

Participating organizations:
Oak Valley Health
ThoughtWire Corp.
Unionville Home Society
Yee Hong Centre for Geriatric Care

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance patient, caregiver, and provider experience
- Improve patient outcomes and population health
- Improve value

cQIP

- Improve overall access to care in the most appropriate setting

OHT Goals

- Seamless transitions & integrated care

PHYSICIAN ENGAGEMENT

INITIATIVE: Town Hall

- The 2nd Annual EYRND OHT Town Hall took place on September 26, 2023, with the goal to continue strengthening communications between EYRND OHT and primary care physicians in order to foster long-term connected care
- In-person town hall provides opportunities for networking for over 115 members, a platform for information sharing of strategic priorities of EYRND OHT, and discuss ways to meet the needs of patients and providers and improve access to care in the community
- Attendees included primary care physicians, dignitaries, and community partners
- Agenda topics included:
    - Fall surge planning, vaccines & prevention by Dr. Fareen Karachiwalla (York Region Public Health)
    - Human trafficking in York Region by Dr. Amanda Adams

Participating organizations:
Oak Valley Health
Ontario Medical Association

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance provider experience

OHT Goals

- Primary care integration

POPULATION HEALTH MANAGEMENT

INITIATIVE: Collaborative Quality Improvement Plan (cQIP)

- An improvement plan that aligns provincial and local health system priorities with the Quintuple Aim and considers populations most at risk with three areas of focus:
  - Preventative health
    - The successful development of pathways linking Carefirst Family Health Team's (FHT) Women's Health Program and Health For All FHT's Women's Clinic allowed the OHT to build an integrated model of care which addressed health literacy and cancer screening access for newcomers and immigrant women
    - Significant engagement efforts were undertaken to better understand the landscape of cancer screening processes and barriers within the OHT, including the development of a current state assessment and an environmental scan on community needs and methods of accessing information
    - The OHT additionally conducted a thorough gap analysis by engaging its health care system users with the aim of exploring how newcomers, immigrants, unattached residents, and patients without OHIP may prefer to access information
  - Mental health and addictions
    - To help address the increasing mental health and substance use concerns, a Mental Health and Addictions Wellness Centre (MHAWC) to support individuals in Markham-Stouffville-North Durham was successfully established. This Wellness Centre provides pharmacotherapy for individuals seeking addictions medicine support, harm reduction education and awareness, case management, counselling, and referrals to other community services
    - The Under One Roof (UOR) project was successful in its development and informed OHT communications. UOR employed a community dialogue model as well as deep engagement with the community, which allowed the OHT to better understand the needs of a vulnerable subsection of our attributed population

STRATEGIC PLAN ALIGNMENT

Quintuple Aim

- Enhance patient, caregiver, and provider experience
- Improve patient outcomes and population health
- Improve value
- Advance health equities

cQIP

- Improve overall access to care in the most appropraite setting
- Increase overall Access to community mental health and addiction services
- Increase overall access to preventative care

- Alternate level of care (ALC)
  - The OHT has successfully delivered on its commitment to optimize hospital capacity and patient flow through appropriate community placement of patients designated as ALC
  - Teams have embarked on weekly transitional care huddles to identify barriers; onboarded a full-time integrated care coordinator to address timely appropriate ALC transfers to Transitional Care Unit (TCU) locations; implemented daily reporting of TCU occupancy; and relocation of the TCU to improve capacity and accommodation for high needs patients. Through the above activities, the OHT has improved on its ALC management processes, facilitated increased program occupancy, and enabled timely and coordinated care and transitions
  - The OHT completed its ALC leading practices self-assessment from both an OHT and a hospital perspective. Insights from the self-assessment informed an environmental scan involving all ALC management partners within Oak Valley Health

STRATEGIC PLAN ALIGNMENT

OHT Goals

- Primary care integration
- Seamless transitions & integrated care
- Reduce health inequities
- Community empowerment
- Patient & provider navigation
- OHT maturity

Elevating Excellence:

THE JOURNEY TOWARDS SEAMLESS CARE

Acknowledgements: We would like to acknowledge our partners, volunteers, including students and persons with lived experience, who have helped shape the evolution of the EYRND OHT. Our goal is to continue working alongside people with lived experience to ensure their voices are heard. Thank you dedicating your time and sharing your insights. The contributions helped us improve the patient and caregiver experience by connecting them to the appropriate services seamlessly and effectively.

Eastern York Region North Durham
EYRND ONTARIO HEALTH TEAM