Mobilizing a Whole Community:
Policy and Strategy Implications of an Integrated Local System Response to a Global Health Crisis

Anne Wojtak, Jason Altenberg, Carol Annett, Anne Babcock, Keith Chung, Sarah Downey, Mark Fam, Ian Fraser, Kate Mason, Thuy-Nga (Tia) Pham, Jeff Powis, Ashnoor Rahim, Jarred Rosenberg and Catherine Yu

Abstract

The East Toronto Health Partners (ETHP) include more than 50 organizations working collaboratively to create an integrated system of care in the east end of Toronto. This existing partnership proved invaluable as a platform for a rapid, coordinated local response to the COVID-19 pandemic. Months after the first wave of the pandemic began, with the daily numbers of COVID-19 cases finally starting to decline, leaders from ETHP provided preliminary reflections on two critical questions: (1) How were existing integration efforts leveraged to mobilize a response during the COVID-19 crisis? and (2) How can the response to the initial wave of COVID-19 be leveraged to further accelerate integration and better address subsequent waves and system improvements once the pandemic abates?

Introduction

Our global population is experiencing the impact of the current COVID-19 pandemic at every level, from health systems and economies to cultural institutions and societal behaviours. In Canada, as our federal and provincial governments take steps to address the immediate crisis, we also need to begin assessing the long-term policy implications. In the post-SARS period, the evaluation of the response prompted significant shifts in the organization of public health as well as within our health system. We are already aware that the breadth and duration of impact from COVID-19 will be considerably greater.

In the past few years, despite making strides to better connect our health system, Ontario still lags behind other jurisdictions in health system integration. While just prior to the pandemic the Ontario Health Team strategy had been gaining momentum, Ontario's COVID-19 response has made it even more apparent that we need to accelerate our healthcare integration work.[1] In East Toronto, the value of our existing integration efforts has been evident in our ability to mobilize our community partners and our entire primary care network to help stem the tide of the coronavirus pandemic.

While European countries, including Italy and Spain, and US states such as New York were hit hard earlier in the pandemic, Canada had more time to prepare. As a result, Canada did not see its acute care hospitals overwhelmed with patients. Instead, the virus has had the highest impact among frail seniors living in long-term care homes, where over 80% of our fatalities to date have occurred. In addition, our large urban centres, including Toronto and Montreal, have experienced the highest concentration of positive cases, with inequitable distribution among racialized communities and economically and socially disadvantaged, high-density neighbourhoods. This is also the case in East Toronto, in which there is significant variation in the prevalence of COVID-19 by neighbourhood.

This paper outlines the early learnings from an integrated local health system response in East Toronto to the

COVID-19 pandemic and preliminary reflections on the long-term policy and strategy implications for the future direction of our healthcare system.

The East Toronto Health Partners

The East Toronto Health Partners (ETHP) is a network of healthcare and social services organizations that have partnered to better integrate care in our East Toronto community of over 300,000 residents.[2] Many of these partners have a 25-year history of working together to improve local healthcare. In late 2017, the chief executive officers (CEOs) of five organizations that represent the continuum of healthcare came together to form the foundation for an integrated care network (ETHP).[3]

The ETHP is governed through a "network of networks" model in which each small group of anchor partner organizations represents a different care sector or provider network, for example, long-term care or home care. The exception to this network model is Michael Garron Hospital (MGH), a 500-bed community teaching hospital, which is the only acute care hospital in East Toronto. The East Toronto Family Practice Network (EasT-FPN), representing the voice of over 270 local family physicians in our Ontario Health Team, signed as the newest anchor partner in fall 2019. The ETHP leadership table includes the executive leaders of the anchor partner organizations as well as patient and caregiver representatives. This leadership team partners with more than 50 other health and social services organizations to improve how local care is coordinated and delivered. In December 2019, the Ontario minister of health named ETHP as one of the first Ontario Health Teams.

Understanding How We Leverage Integrated Care during and after a Health System Crisis

The shift toward more integrated systems of care is happening globally as governments and health systems grapple with multiple challenges, including the growing numbers of individuals with multiple complex and chronic health conditions in a time of increased financial pressures. Integrated care is seen as an important means to achieve the quadruple aim of improving patient experience, reducing costs, improving population health and improving clinician experience. Despite the evident value in shifting to greater integration, creating and leading integrated systems of care are a complex undertaking. The collaboration required to create a "one team" approach across multiple health and social services providers involves modifying how diverse organizations and professionals work and how they interact (Evans et al. 2016). Achieving such a high level of system transformation in how care is delivered requires a multifaceted strategy that addresses both technical (funding, policy, care pathways) and human factors (relationships, trust, adaptive leadership, engagement, shared values; Evans et al. 2016; Goodwin 2013).

The coronavirus pandemic hit just as Ontario had started accelerating its shift to integrated care through its Ontario Health Team strategy. Although there is limited research on the value of integrated care in the management of large-scale disasters, as the COVID-19 crisis escalated, we noted that the factors critical to the success of developing integrated systems of care and responding to large-scale healthcare emergencies are similar. Both scenarios are complex and dynamic, requiring a shared sense of purpose, trusted personal and organizational relationships across different sectors, distributed leadership and a strong role for organized primary care networks (Pham et al. 2020).

With Ontario now moving to a later stage in the COVID-19 crisis, two questions come to mind:

1. How were existing integration efforts leveraged to mobilize a response during the COVID-19 crisis?
2. How can the response to the initial wave of COVID-19 be leveraged to further accelerate integration and to better address subsequent waves and system improvements once the pandemic abates?

Leveraging a Local Integrated System to Mobilize a Response to COVID-19

Analyzing the initial response of the ETHP to the COVID-19 pandemic has provided tremendous insights into the value of integrated systems of care. When broad community transmission began in China in early January, followed by the first presumptive case of COVID-19 in Canada, leaders from our EasT-FPN and community health centres connected immediately with the infection control specialists at MGH and came together to create a plan for our community. This partnership between the hospital and local primary care enabled rapid, shared planning and implementation of a number of critical steps to stave off the acute care crisis that was experienced by other countries. These critical steps include the following:

- assessing personal protective equipment (PPE) stocks, prioritizing supply distribution and mask-fit testing for all community clinicians in East Toronto;
- exploring solutions to divert potentially infected, lower-needs patients from the hospital, including opening a community-based testing and assessment centre;
- establishing trusted communications channels, including weekly calls for all family physicians and leaders from community partner organizations, with the hospital's infection control physician lead, and utilizing the EasT-FPN website as a centralized source of up-to-date information for local family practices;
- staffing the assessment centre using a rotational schedule of family physicians and nurse practitioners from across the community, which enabled the hospital to focus

emergency department physicians and other hospital specialists on patients requiring acute care;
- creating hospital capacity by shifting patients to alternate care settings through new and innovate partnerships, including establishing acute care replacement beds in a local retirement home supported by homecare provider staff and establishing adult palliative care beds in a local children's hospice;
- leveraging existing hospital-to-home discharge pathways for patients with chronic diseases as a prototype for a COVID@Home pathway to support both hospital patients being transitioned home and patients who tested positive for COVID through the assessment centres; and
- establishing weekly planning calls for more than 50 health and social services organizations for local problem solving, sharing up-to-date best evidence, decision making, common messaging and sharing human resources practices and ensuring greater consistency in response across our community, thus keeping us a few steps ahead of official provincial communications.

After a few short weeks, it became apparent that unlike in China, Italy, Spain, New York City and other regions impacted earlier by COVID-19, acute care hospitals were not the centre of the pandemic crisis in Ontario. The initial epicentre in East Toronto and across Ontario was long-term care. By mid-March, East Toronto experienced its first outbreak in a long-term care home, which was followed by outbreaks in three other long-term care homes over the next four months. An integrated care response, initiated by MGH specialists and supported by EasT-FPN and homecare partners working side-by-side with long-term care staff, included on-site infection control, PPE distribution, outbreak management, health human resources and staffing support, environmental services for disinfection, rapid testing and contact tracing for residents and staff, direct pathways to the hospital emergency department and access to mobile primary care, nurses and hospital specialists to support care of residents in place.

A recent study by Stall et al. (2020) of 190 COVID-19 outbreaks in long-term care homes in Ontario found an overall case fatality rate of 27.8%. As shown in Table 1, while the case fatality rate for the first long-term care outbreak in East Toronto was 40%, it dropped to 16% by the fourth outbreak. Similarly, all-cause mortality in the first long-term care outbreak was 39%, dropping to 14% by the fourth outbreak. Although further study is required, the successive reduction in mortality rates correlates to progress in the integrated team's response as team members from different organizations learned to work together more seamlessly, used rapid learning cycles to improve infection prevention practices and frontline staff knowledge and provided increasingly coordinated clinical care with long-term care staff to support residents in situ. This integrated outreach support in bringing the hospital to the long-term home was later used by the ETHP to support retirement homes and other seniors' congregate care settings.

TABLE 1.
Case fatality rates for COVID-19 outbreaks in long-term care in East Toronto, March–July 2020

Long-term care home	Date (2020)	COVID mortality (COVID-positive deaths/total COVID-positive residents)	All-cause mortality during outbreak (deaths/ total residents)
#1	March/April	40%	39%
#2	April/May	37%	25%
#3	May/June	33%	21%
#4	June/July	16%	14%

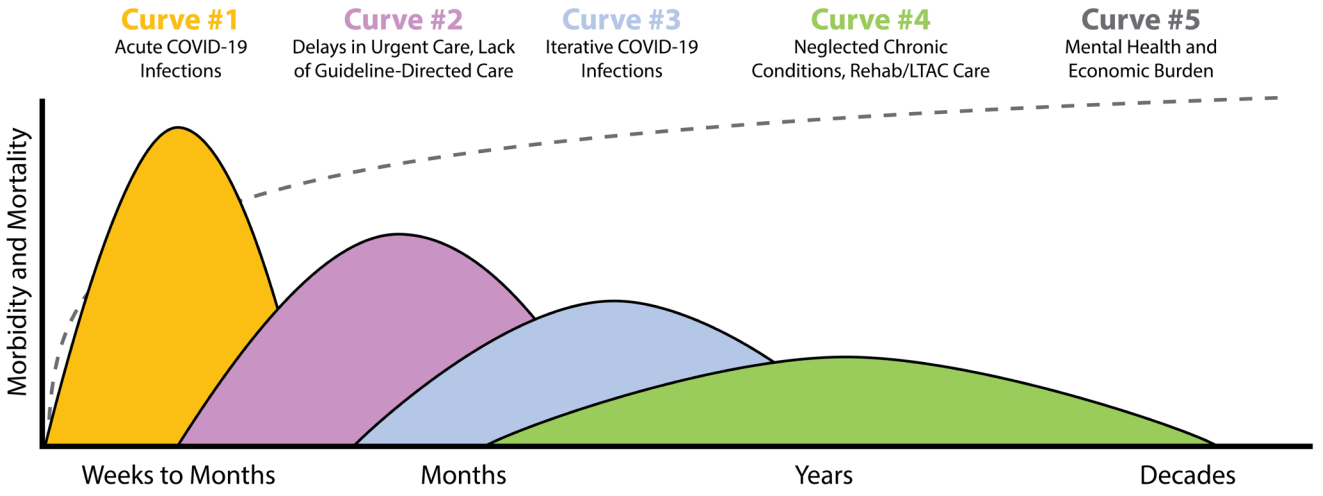
Support for shelters, respite centres and group homes was similarly based on a collaborative response led by the community health centres with support from MGH infection control specialists. This response included biweekly virtual meetings to share best evidence and resources specific to needs of the sector; infection prevention and control assessments and guidance by phone or in person; PPE provision; transportation to the MGH COVID Assessment Centre; system navigation support/referrals; and outbreak management, including rapid on-site testing for residents, contract tracing and streamlined access to COVID recovery/isolation sites. This team-based approach became the model for a proactive Toronto-wide strategy to support residents in shelters with mass testing and physical isolation for recovery. As of August 2020, the infection control specialists from MGH and family physicians from EasT-FPN have also initiated outreach and support for local school principals given the escalating concerns about the potential for school-based outbreaks.

The rapid response of the partnership was enabled by long-established relationships and trust among different provider organizations developed over years of working together. The story of East Toronto's planning for COVID-19 is about mobilizing our acute care, community and primary care providers as a whole and working together in shared purpose. This includes management of pandemic patients outside of the hospital and provision of services that are essential to support a local pandemic response (Pham et al. 2020).

As the pandemic progressed, our local response evolved to prioritize targeted support for vulnerable citizens in the community across different settings and begin addressing the widening health and social implications, as shown in Figure 1.

The physician leaders from EasT-FPN recognized the need to have a plan to address the "second," "third" and potential

FIGURE 1.
Different waves of the COVID-19 pandemic



Source: Reprinted with permission from Kohli and Virani 2020.
*LTAC refers to long-term acute care.

"fourth" waves of the pandemic resulting from the impact of resource restrictions and lack of access to healthcare for people with urgent non-COVID conditions living in the community. Our family physician leadership accelerated the development of four community "hubs," comprising integrated teams of primary care, home care, community care, housing providers and local community volunteers. While these four hubs are still in the development stages, some early successes include the following:

- the development of rapid mobile COVID testing in "hot-spot" neighbourhoods and high-rise residential buildings identified through assessment centre data captured by MGH infection prevention and control specialists;
- the deployment of mobile medical units that enable rapid access to primary care services for at-risk seniors with complex, chronic health conditions living in the community;
- leveraging the knowledge of community partners, such as WoodGreen Community Services and The Neighbourhood Organization, in high-density priority neighbourhoods, such as Thorncliffe Park and Taylor Massey, to provide education to residents about COVID-19 testing, physical distancing, mask wearing and self-screening; distribute cloth masks; support mobile testing; prevent spread by people who test positive; and identify people in need of support; and
- the engagement of community leaders and volunteers (known as "community health ambassadors") to provide culturally sensitive COVID education and support in multiple local languages and access to essential services such as grocery delivery to address needs related to the broader social determinants of health.

Having organized primary care leadership at a local level working in partnership with the acute care hospital and community-based health and social care agencies has proved to be a game changer in the response to COVID-19. It has enabled the ETHP to simultaneously address the immediate, acute implications of the pandemic as well as the ripple effects of broader health and social care needs in our community.

Implications of Our Response to COVID-19 for Accelerating Our Shift to Integrated Care

Our provincial and local system response to COVID-19 is changing healthcare delivery in real time, and decisions and processes will continue to evolve as we manage through the current crisis. As the pandemic subsides, there will be short- and long-term implications for everything, from pandemic planning and supply chain distribution to digital health and advanced care directives. We can anticipate that a future system-wide review will assess the breadth of our COVID-19 response and implications for our future state. While there is ongoing discussion about "returning to normal," normal should not mean "back to the way things were," particularly with respect to how we organize and deliver healthcare in Ontario. In anticipation of our post-COVID context, the following are

some initial reflections from the authors on potential policy implications for leveraging our COVID-19 response to accelerate Ontario's shift to integrated care.

Enabling rapid changes at scale

The adage that "necessity is the mother of invention" has never been truer than in the current crisis. We have seen industries shift from manufacturing cars to manufacturing ventilators or from fashion to surgical masks and 3D printing of face shields and other medical equipment, almost overnight. At a local level, we have supported creative solutions by hospitals and community partners that are prescriptive about staff and patient protection but flexible on out-of-the-box solutions. This creativity is particularly evident in the rapid shift to primary care and specialist e-visits, virtual patient information, care delivery and education, community assessment centres, reporting of test results and sourcing and distribution of medical equipment and supplies. In addition, the use of secure communication platforms among and between primary care and specialists (e.g., texting, e-mail) has accelerated because of the necessity to match the pace of change and the urgency of patient care needs. In the past few months, we have been able to bring down barriers to change, implement rapid learning cycles, repeatedly shift processes for care delivery and quickly adopt innovations. Many of the changes we make now will have long-term implications for how our local system operates and how rapidly we adopt new innovations and change.

As the COVID-19 crisis abates, we will have opportunities to leapfrog in large-scale system transformation and policy change by spreading and scaling the new and different ways we have worked across public and private sectors to address the crisis. The concept of a "rapid-learning health system" (Greene et al. 2012) that leverages information technology, data and analytics and research to enable a cycle of learning in clinical care has become more important than ever. Although the impact of system fatigue will grow the longer the crisis continues, we can also envision that the health system will have reduced appetite for incremental change following the rapid pace of change and learning we have experienced through necessity with COVID-19.

Rethinking care delivery

As the media and public attention on the crisis in long-term care continues to mount, there are increasing calls for system reform for how we provide care and support for older persons. This pressure is occurring because of the devastating impact that COVID has had within our long-term care homes, the short-term implications of reduced bed capacity, the heightened public fear about care homes and the need to expand alternatives such as assisted living and supportive housing, affordable retirement communities, communal living models and home-based care.

In addition, for all client populations, one of the lessons of COVID-19 is that virtual collaboration and care delivery can be effective in supporting some patient populations. The use of virtual and digital solutions vastly expands care options by enabling clients, families, caregivers and healthcare providers to access support 24/7 for care at home. During the pandemic, we have expanded access to hospital services, primary care and even home and community care (such as virtual rehabilitation and access to volunteer supports) through virtual visits. However, this must be balanced with the growing digital divide that we are experiencing as some of our patient populations face significant barriers in accessing and using technology, including access to mobile devices and sufficient Wi-Fi bandwidth.

The adage that "necessity is the mother of invention" has never been truer than in the current crisis.

While family physicians have accelerated their use of e-visits for patients, the ETHP have also leveraged programs such as Seamless Care Optimizing Patient Experience (SCOPE) and access to the MGH Hypercare system, both of which enable community physicians to connect with hospital-based specialists virtually. Rapid access to advice from specialists (as well as access to interprofessional care teams from different organizations) is enabling primary care practitioners to increase their capacity to support patients at home. We can anticipate that post COVID, there will be even greater pressure to expand access to virtual care beyond the new focus on physician, specialist and mental health e-visits to include virtual care options for rehabilitation, pharmacy, homecare rehabilitation and nursing, adult day programs, family caregiver supports and other care resources.

Faster shift to focus on population health

In a mature state of integrated care, there is an interconnected and coordinated system that addresses social determinants of health to improve the overall health and well-being of citizens. When the first Ontario Health Teams were approved in late 2019, it was expected that in their first year of operation they would start by integrating care for one to three specific patient populations, for example, individuals with chronic conditions such as diabetes, people who need post-acute care or other such groupings. Over time, the Ontario Health Teams would then expand their reach until they had successfully integrated care for their full population.

Early evidence indicates that both the incidence and effects of COVID-19 are unequally distributed across populations. People with complex health needs, vulnerable populations and people with increased material and social deprivation are at increased risk (Anderson et al. 2020). Among East Toronto's

diverse communities, there are four City of Toronto–designated neighbourhood improvement areas with higher health and social disparities. These neighbourhoods include greater proportions of new immigrants, people who are racialized and people with lower socio-economic means, many of whom are in jobs that have higher exposure risk to COVID-19, such as taxi drivers, grocery store workers and personal support workers.

As the pandemic escalated, the ETHP focused our COVID-19 strategy on care and prevention for older persons with chronic disease, which was known to be the highest-risk group. We soon expanded our efforts to a population-based approach that started with identifying higher-risk neighbourhoods. This included establishing partnerships with local community leaders, volunteers and organizations in those neighbourhoods to address the breadth of impact of COVID-19 on everything, from culturally appropriate prevention education to issues of food insecurity and housing.

As a next phase, we are anticipating the need to step more into public health functions by creating an East Toronto–wide infection prevention and control program, accelerating routine pediatric vaccinations for children that have lapsed during the pandemic and increasing access to seasonal flu vaccines. At the time of writing, we had just initiated outreach and support for local school principals in preparation for the potential of school outbreaks. COVID-19 has shifted the focus of ETHP to overall population health more rapidly than we anticipated. We are now in the process of recalibrating what this means for our priorities, going forward, which brings us to the next reflection point (the next section).

We soon expanded our efforts to a population-based approach that started with identifying higher-risk neighbourhoods.

Rethinking roles and responsibilities for public health and healthcare

After the severe acute respiratory syndrome (SARS) outbreak in Toronto in 2003, Ontario invested in increased infection and prevention control (IPAC) expertise in hospitals. This investment, with specific recommendations for a ratio of infection control practitioners (ICPs) to acute care beds of 1:100, left the province with a legacy of world-recognized expertise in IPAC. At the same time, the emergence of COVID-19 has demonstrated the vulnerabilities within the public health system, including capacity for testing, reporting, counselling and contact tracing.

One of the challenges of our current response to COVID-19 has been the dichotomy between our public health systems and our healthcare systems. Testing and treatment of COVID-19 are managed through healthcare providers, while contact tracing and contact notifications are managed through our public health systems. While this approach has worked well under regular circumstances of infectious disease reporting, in regions of Ontario with high numbers of COVID-19 cases, public health staff have been overwhelmed, resulting in delays in the cycle of testing, contact tracing, contact notification and education for persons who test positive. This has made it more challenging to contain community spread of the virus.

In East Toronto, we have been able to leverage the deep connections of our community partner organizations and local family physicians to provide education and mobilize testing across different neighbourhoods. Having these connections has been a significant advantage in being able to create targeted strategies for racialized and minority populations that have been hit the hardest by COVID-19. The MGH infection control team is also initiating contact tracing for patients who test positive in the assessment centres and is using data from the assessment centres to identify emerging hot spots for community spread.

As we enter the next phase of COVID-19, we see opportunities to better integrate the functions of testing, contact follow-up and data management to create more rapid follow-up cycles. This includes rethinking the roles and responsibilities of public health and healthcare to shorten the time between testing and contact tracing, increase human resources capacity and better integrate data systems to proactively reduce community spread.

The critical importance of organized primary care

Best practice evidence identifies the organization of primary care and primary care leadership as essential building blocks in the success of integrated healthcare systems (Alderwick et al. 2015; Goldsmith 1994; Leatt et al. 2000; Nicholson et al. 2013; Valentijn et al. 2013). As ETHP started the application process to become an Ontario Health Team, community health centres were a partner in the leadership team, but we struggled to achieve the broader engagement across primary care needed to achieve our goals. This changed in October 2019 when ETHP welcomed our newest anchor partner, EasT-FPN, which was created to be the representative voice of the over 270 family physicians in East Toronto.

Not only has the increased connection to family practice helped accelerate our integration initiatives, but as noted earlier, when the COVID-19 crisis started to escalate, this level of local organized physician leadership and diversity of voices proved invaluable. Ontario can now anticipate increased pressure for networks to form in regions with large numbers of unaffiliated family physicians as well as the need for sustainable funding for network infrastructure and physician engagement.

Implications for funding models and resource sharing

It is already clear that COVID-19 is having a significant, negative impact on our economy. The loss of tax revenue and economic output combined with the need for rapid scale-up of investment to fight the pandemic will leave a significant funding shortfall for governments. Given that healthcare delivery represents over 50% of Ontario's total expenditures, we can expect a difficult recovery from COVID-19 on many levels, including the following five specific implications of COVID on healthcare resources:

Greater emphasis on sharing scarce resources

Two years ago, as the five founding organizations of the ETHP started formalizing their relationship, they contemplated the eventuality of shared funding and resources. This manifested in a signed joint venture agreement between the anchor partners, the creation of shared leadership roles across the organizations as well as initial shared funding arrangements, such as the use of MGH's annual flu surge funds, from the past two winter seasons, to build additional capacity for patient care across community partners.

These first experiences in sharing resources across the partners laid the groundwork for important and rapid decisions made in the early stages of the COVID-19 pandemic, including leveraging winter flu surge funds from the hospital to make arrangements for mask-fit testing and PPE distribution for local family practices, shared staffing arrangements for the assessment centre and granting temporary hospital privileges to all family physicians in EasT-FPN who did not already have them. Through recent regulatory changes, the provincial government is supporting greater flexibility and movement of staff within organizations (Government of Ontario 2020). However, in the future of Ontario Health Teams, we can also envision greater capacity to move staff and funding between organizations to facilitate greater flexibility with patient care and greater blurring of lines between providers as we move closer to creating a "one team" approach to delivery of care for patients and their families.

Greater pressure to move from fee-for-service to alternate payment models

Front-line healthcare delivery has been a significant focus over the past few months, particularly within hospitals and long-term care. At the same time, we experienced lower demand for primary care and home care when family physician offices temporarily closed and families cancelled homecare services to reduce the risk of exposure to the coronavirus. In Ontario, both primary care and publicly funded home care are dominated by fee-for-service payment models. As a result, both sectors have been severely financially impacted by the pandemic as care volumes and revenue dropped but costs related to pandemic supplies remained fixed or even increased. We are already seeing this financial pressure force the closure of some primary care clinics, including those by family physicians choosing to take early retirement. This dichotomy in how different healthcare sectors were impacted will likely make alternate funding models such as capitation, flat fee or bundled payments and salaried models much more attractive for the future.

Closing the gap in wage and workplace disparities

With the devastating loss of life in long-term care homes in Canada, COVID-19 has shed greater light on the economic disparity of workers across different healthcare settings. The Government of Ontario is preparing to conduct a review of the situation in long-term care homes, but initial reports indicate that existing cracks in the system were exacerbated by the pandemic. Lower wages in long-term care and home care, with fewer available full-time positions, meant that many staff worked in multiple care settings and/or for multiple employers. Personal support workers, who make up the majority of the workforce in both long-term care and home care, include a higher proportion of women from racialized and immigrant communities, particularly in urban locations. These workers were already disadvantaged by lower-paid positions, which were often part-time or casual, and when the pandemic began, those in long-term care were among the last healthcare staff to be equipped with adequate PPE. Of the nine healthcare workers in Ontario known to have died from COVID-19, six were personal support workers (Canadian Federation of Nurses Unions 2020). While no homecare workers are known to have been infected by COVID-19 on the job, many workers have not returned to work because of financial reasons and/or lack of access to adequate childcare. Reducing disparities in pay and working conditions will be important factors in rebuilding health human resources capacity and trust in both the long-term and homecare sectors.

Rethinking care spaces

As in many other industries that have recognized the workforce implications of the pandemic, including work-from-home and virtual meetings, healthcare and social services too are facing a reassessment of care delivery spaces. For acute care, long-term care and other institution-based care, capacity has been significantly reduced as we are forced to accommodate fewer patients or residents in existing spaces. Among our 50+ community partner organizations, we are discussing how to reopen programs and services that were closed during the pandemic. This includes day programs, mental health services and a host of social programs designed to improve the health and well-being of community members.

Many of our existing spaces are no longer suitable for

care delivery or gatherings because they do not facilitate physical distancing or have aging infrastructures that lack adequate air circulation. We can anticipate that many organizations will need to re-evaluate their real estate, potentially downsizing, moving, renovating and/or choosing to co-locate with other partners. Although this may create opportunities for further integration, there are also additional costs to set up appropriate care settings across our health and social services organizations.

Ethical decision making and health equity

As we think about how to share and utilize scarce resources, our health system will need to expand our thinking on how priorities are set and decisions are made. Early in the pandemic, based on experiences in regions that were hit hard, Ontario focused on creating ethical frameworks for immediate high-stakes decisions, such as access to ventilators. While individual organizations may have developed ethical frameworks for operating during the pandemic, as a system, we defaulted to prioritize acute care services while miscalculating the risks for long-term care, congregate care settings, homeless shelters and low-income and racialized communities. As we look ahead, we will need to broaden our ethical frameworks to guide decisions about priority setting and resource allocation beyond acute care and truly shift the focus of care delivery to primary care and community-based care and accelerate targeted actions to reduce health and social inequities among our local populations.

Community engagement and mobilization

Engaging patients, caregivers and communities is a key success factor for creating integrated systems of care and a requirement for being designated an Ontario Health Team. Over the past three years, engagement of patients, families and community members has been an increasingly important part of our local integrated care work. However, over the past few months in East Toronto, we did not sufficiently leverage the power of our patients and consumer voices in managing our pandemic response. This is something ETHP are reflecting on as we plan for a potential COVID-19 second wave and annual influenza season starting in the fall.

Although we still have significant work to do to better connect our patients, caregivers and community to our integration efforts, we have been amazed and humbled by the support of our community in the current crisis. MGH was among the first hospitals to launch a community campaign for donations of PPE. The campaign was championed by the medical director of the hospital's critical care unit and supported by the MGH Foundation. After only a couple of weeks, the campaign was so successful that the idea quickly spread to other hospitals. In addition, MGH pioneered a homemade mask strategy, providing a sewing template and inviting local residents to contribute home-made masks for use by community members and hospital visitors. To date, the hospital has received 180,000 cloth masks, and with the support of community partners, it has distributed 170,000 of these masks back to the community.

Given that the future of healthcare in Ontario is a population-based approach, we understand we will need even stronger engagement from communities to co-design healthcare solutions and to draw upon the strength and resiliency of our communities to build a system that works better for all of us.

Conclusion

For ETHP, we fully believe that our investment in building our core partnership over more than two decades helped accelerate and shape our initial response to the novel coronavirus. It is difficult to imagine how we could serve our local population through this crisis without our integrated way of working. As we look to the future, we recognize that our outlook is different from how we imagined it would be. If there is a silver lining to this terrible pandemic for Ontarians, it is that we avoid returning to a "normal" state and instead emerge with a stronger, more resilient and more integrated healthcare system. HQ

Acknowledgements

The authors acknowledge a tweet by Dr Victor Tseng as the original source of Figure 1 (Different waves of the COVID-19 pandemic) in this article. The tweet can be found at: https://twitter.com/VectorSting/status/1244671755781898241.

Notes

1. Ontario Health Teams (OHTs) are part of the Government of Ontario's strategy to better connect health and social care providers (including hospitals, home care, family physicians/primary care and community care) to make it easier for patients and families to receive more integrated care close to home. Regional partnerships were required to participate in a self-assessment and submit a formal OHT application to the provincial government. The first 24 OHTs were announced by the Ontario Ministry of Health at the end of 2019. See: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/#OHT.
2. The East Toronto boundaries span from the Don River to the west to Warden Avenue in the east, and from south of Eglinton Avenue to Lake Ontario, and include priority neighbourhoods such as Thorncliffe Park and Flemingdon Park. We also serve Ontarians across the Greater Toronto Area and beyond, for a total attributed population of 375,000.
3. The five founding organizations are Michael Garron Hospital – Toronto East Health Network, Providence

Healthcare – Unity Health Toronto, South Riverdale Community Health Centre, VHA Home HealthCare and WoodGreen Community Services.

References

Alderwick, H., C. Ham and C. Buck. 2015, February. *Population Health Systems: Going Beyond Integrated Care*. The King's Fund. Retrieved March 22, 2020. <https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf>.

Anderson, G., J.W. Frank, C.D. Naylor, W. Wodchis and P. Feng. 2020. Using Socioeconomics to Counter Health Disparities Arising from the COVID-19 Pandemic. *BMJ* 369: m2149. doi:10.1136/bmj.m2149.

Canadian Federation of Nurses Unions. 2020, June 5. In Memoriam: Canada's Health Care Workers Who Have Died of COVID-19. Retrieved August 12, 2020. <https://nursesunions.ca/covid-memoriam/>.

Evans, J., S. Daub, J. Goldhar, A. Wojtak and D. Purbhoo. 2016. Leading Integrated Health and Social Care Systems: Perspectives from Research and Practice. *Healthcare Quarterly* 18(4): 30–35. doi:10.12927/hcq.2016.24553.

Goldsmith, C. J. 1994. The Illusive Logic of Integration. *Healthcare Forum Journal* 37(5): 26–31.

Goodwin, N. 2013. Taking Integrated Care Forward: The Need for Shared Values. *International Journal of Integrated Care* 13(2): e026. doi:10.5334/ijic.1180.

Government of Ontario. 2020. Ontario Regulation 74/20: Work Redeployment for Certain Health Services Providers. Retrieved April 1, 2020. <https://www.ontario.ca/laws/regulation/200074>.

Greene, S. M., R. J. Reid and E. B. Larson. 2012. Implementing the Learning Health System: From Concept to Action. *Annals of Internal Medicine* 157(3): 207–10. doi:10.7326/0003-4819-157-3-201208070-00012.

Kohli, P. and S. S. Virani. 2020. Surfing the Waves of the COVID-19 Pandemic as a Cardiovascular Clinician. *Circulation* 142(2): 98–100. doi:10.1161/CIRCULATIONAHA.120.047901.

Leatt, P., G.H. Pink and M. Guerriere. 2000. Towards a Canadian Model of Integrated Healthcare. *Healthcare Papers* 1(2): 13–35. doi: 10.12927/hcpap..17216.

Nicholson, C., C. Jackson and J. Marley. 2013. A Governance Model for Integrated Primary/Secondary Care for the Health-Reforming First World – Results of a Systematic Review. *BMC Health Services Research* 13: 528. doi:10.1186/1472-6963-13-528.

Pham, T.-N., J. Powis, M. Fam, I. Fraser and A. Wojtak. 2020. Early Lessons: Tackling a Global Crisis with a Community Response. Insights (Essays). Retrieved March 20, 2020. <https://www.longwoods.com/content/26167//early-lessons-tackling-a-global-crisis-with-a-community-response>.

Stall, N.M., A. Jones, K.A. Brown, P.A. Rochon and A.P Costa. 2020. For-Profit Long-Term Care Homes and the Risk of COVID-19 Outbreaks and Resident Deaths. *CMAJ* 192(33): E946–55. doi:10.1503/cmaj.201197.

Valentijn, P.P., S.M. Schepman, W. Opheij and M.A. Bruijnzeels. 2013. Understanding Integrated Care: A Comprehensive Conceptual Framework Based on the Integrative Functions of Primary Care. *International Journal of Integrated Care* 13(1): e010. doi:10.5334/ijic.886.

About the Authors

Anne Wojtak, DrPH, MHSc, BSc, is the lead for integrated care for ETHP and adjunct faculty, Institute for Health Policy Management and Evaluation, Dalla Lana School of Public Health, University of Toronto in Toronto, ON. She can be reached by e-mail at anne.wojtak@tehn.ca.

Jason Altenberg, MSW, BSc, is president and CEO of the South Riverdale Community Health Centre in Toronto, ON.

Carol Annett, MBA, MSW, BA, is president and CEO of VHA Home HealthCare in Toronto, ON.

Anne Babcock, BA is president and CEO of WoodGreen Community Services in Toronto, ON.

Keith Chung, JD, BSc, is president of Magenta Health Inc. and president of EasT-FPN in Toronto, ON.

Sarah Downey, MHA, BSc, CHE, is president and CEO of MGH, Toronto East Health Network in Toronto, ON.

Mark Fam, MHA, BScH, CHE, is vice-president of programs at MGH, Toronto East Health Network, and adjunct faculty, Institute for Health Policy Management and Evaluation, Dalla Lana School of Public Health, University of Toronto in Toronto, ON.

Ian Fraser, MD, FRCPC, is the chief of staff at MGH, Toronto East Health Network in Toronto, ON, and director of the Provincial Prolonged-Ventilation Weaning Centre of Excellence.

Kate Mason, MHSc, BAH, is the research coordinator at South Riverdale Community Health Centre in Toronto, ON.

Thuy-Nga (Tia) Pham, MD, MSc, CCFP, FCFP, is the physician lead for the South East Toronto Family Health Team, associate professor at the Department of Family and Community Medicine, University of Toronto and treasurer of EasT-FPN in Toronto, ON.

Jeff Powis, MD, FRCPC, MSc, is the medical director of infection prevention and control at MGH, Toronto East Health Network, and assistant professor, Department of Medicine, University of Toronto in Toronto, ON.

Ashnoor Rahim, MBA, BScPT, is vice-president, Community Care at WoodGreen Community Services in Toronto, ON.

Jarred Rosenberg, MD, FRCPC, MSc, is a geriatrician at MGH, Toronto East Health Network, and lecturer, Department of Medicine, University of Toronto in Toronto, ON.

Catherine Yu, MD, MSc, BSc, CCFP (EM), FCFP, is the physician lead for Health Access Thorncliffe Park and chair of EasT-FPN in Toronto, ON.