Hamilton Health Team

Self-assessment of readiness to become an Ontario Health Team

May 15, 2019

Ontario Health Team Self-Assessment
Hamilton Health Team

Part I: General Information and Commitments

Who are the members of your team?

Please identify the list of health care providers and/or organizations that would partner to form the proposed Ontario Health Team. Please explain why this group of providers and organizations has chosen to partner together.

Our list of partners who have chosen to work together to form our proposed Ontario Health Team is as follows:

- Alzheimer Society (mental health, community support services)
- City of Hamilton
    - City of Hamilton Public Health (health promotion and disease prevention, mental health and addictions)
    - Hamilton Paramedic Service (emergency health services)
    - Human Services and Long-Term Care (community and social services including housing, long-term care)
- Canadian Mental Health Association – Hamilton (community mental health and addictions)
- De dwa da dehs nye>s Aboriginal Health Centre (primary care, community support services, housing, mental health and addictions, social programming)
- Good Shepherd Centres (community mental health and addictions)
- Hamilton Family Health Team (primary care, mental health and addictions)
- Hamilton Health Sciences (child and youth mental health, emergency health services, palliative care, rehabilitation and complex care, pediatrics)
- Indwell (community mental health and addictions)
- Lynwood Charlton Centre (community mental health and addictions)
- McMaster Family Health (primary care)
- McMaster University (digital health, health promotion and disease prevention)
- Ontario Telemedicine Network (digital health)
- SE Health (home care and community support services, palliative care, pediatric care)
- St Joseph's Healthcare System
    - St. Joseph's Healthcare Hamilton (emergency health services, mental health and addictions, palliative care, rehabilitation and complex care)
    - St. Joseph's Home Care (home care and community support services)
    - St. Joseph's Villa (community support services, long-term care)
- Thrive Group (AbleLiving Services, Capability Support Services, St. Peter's Care Centres and Idlewyld Manor) (community support services, long-term care, homecare, palliative care)
- Wayside House of Hamilton (community mental health and addictions)
- Wesley Urban Ministries (community mental health and addictions)

In addition to the partners listed above, our team's Steering Committee is co-chaired by two Patient and Family Advisory Council representatives, Bernice King and John Fleming. The eHealth office has provided a letter of support for this work (provider of ClinicalConnect and MyChart) in **Appendix L**.

Several of the above organizations are members of the Hamilton Community Health Working Group and have closely collaborated previously on numerous population health focused activities. As partners of a new "Hamilton Health Team" we are very confident we can leverage our collective *experience, passion* and *commitment* to advance and expand our impact and efforts to create *meaningful change* for our city of Hamilton. This group of providers brings the experience, reach, scope of services and track record of partnership that is needed to transform the delivery of health and social services in Hamilton.

Commitment to collaborate with others
Please confirm that you are willing to work and engage with other interested groups in your geographic area to collaborate towards becoming an Ontario Health Team, if recommended by the Ministry We enthusiastically confirm our willingness and commitment to work and engage with other interested groups in our geographic area, to collaborate towards becoming an Ontario Health Team. To align our team on the principles and objectives of our emerging Ontario Health Team, we have jointly developed and signed a Charter to reflect our commitment to working together (**Appendix A**).

Commitment to the Ontario Health Team vision
Please confirm that all proposed partners have read the Ontario health Teams: Guidance for Health Care Providers and Organizations in full and are committed to working towards implementation of the Ontario Health Team Model. We confirm that all proposed partners have read the Ontario Health Teams: Guidance for Health Care Providers and Organizations in full and are committed to working towards implementation of the Ontario Health Team Model. Our commitment is further outlined in the project Charter (**Appendix A**).

Part II: Self-Assessment Scoring

Model Component 1: Patient Care and experience

At maturity, Ontario Health Teams will offer patients, families, and caregivers the highest quality care and best experience possible. Patients will be able to access care when and where they need it and will have digital choices for care. Patients will experience seamless care from providers who work together as a team. They can access their health information digitally, and their providers ensure they know what to expect in each step of their care journeys. Patients can access coordination and system navigation services whenever they need to.

You can identify opportunities and targets and can propose a plan for improving access, transitions, and coordination of care, and key measures of integration	X	
You are able to propose a plan for enhancing patient self-management and/or health literacy for at least a specifically defined segment of your Year 1 population	X	N/A
You have the ability and existing capacity to coordinate care access multiple providers/settings for Year 1 patients and you will be able to quantify this capacity (e.g. FTE count)	X	N/A
Your team is committed to:		
Measuring and reporting patient experience accordingly to standardized metrics and improving care based on findings	X	N/A
Putting into place 24/7 coordination of care and system navigating services, available for Year 1 patients who require or want these services	X	N/A
Offering one or more virtual care services to patients	X	N/A
You are able to propose a plan to provide patients with some digital access to their health information	X	N/A

Self-Assessment Scale for Patient Care and Experience
Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons

O-O-O-O-O-O-O-O-O-X

Your team is able to meet fewer than 3 of the requirements of above

Your team is able to meet all of the requirements above

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

The organizations who are collaborating on this submission are passionate about improving experiences for patients, families, and caregivers in Hamilton. We are building upon our past two years of collaboration towards a long-term population health approach, balanced with a short-term focus on improving access, transitions, and coordination of care for two population segments in Year 1:

- Seniors with multiple chronic conditions; and
- Individuals with mental health and addictions conditions.

We will deliver on these commitments by:

1. **Scaling successful initiatives:**

The Integrated Comprehensive Care (ICC) program provides patients with a single coordinated care team, one number to call, and a patient-accessible single EHR (**Appendix B**).

The Hospital to Home program (Health Links philosophy) bridges gaps across sectors for patients with high service utilizations and poor health outcomes (**Appendix C**).

The SMArTVIEW post-acute surgical recovery program provides remote automated monitoring, virtual recovery support and self-management.

By expanding and coordinating these programs, we are committed to creating the first-in-Ontario bundled care program inclusive of primary care and social services. Our approach will focus on social determinants of health in order to improve population health outcomes.

2. **Being results-oriented:**

We will build on our integrated care successes that have shown reduced ED visits, readmission rates, ALC rates, and improved patient experience **(Appendix B, C)**. We are committed to holding ourselves accountable for and measuring the end-to-end experience of patients.

3. **Leveraging digital assets:**

We will use existing digital health and virtual care solutions to support Year 1 care redesign needs (Model Component 8).

Model Component 2: Patient partnership & Community Engagement

At maturity, Ontario Health Teams will uphold the principles of patient partnership, community engagement, and system co-design. They will meaningfully engage ad partner with – and be driven by the needs of – patients, families, caregivers, and the communities they serve.

[illegible]	[illegible]	[illegible]
Each partner in the team can demonstrate a track record of meaningful patient, family, and caregiver engagement and partnership activities[1]	X	
You are able to propose a plan for how you would include patients, families, and/or caregivers in the governance structure(s) for your team and put in place patient leadership	X	N/A
Your team is committed to:		
The Ontario Patient Declaration of Values	X	N/A
Developing a patient engagement framework	X	N/A
Developing a team-wide, transparent, and accessible patient relations process for addressing patient feedback and complaints and a mechanism for using this feedback for continuous quality improvement	X	N/A
If you intend to involve patients, families, and caregivers in the design and planning of a subsequent Full Application(if invited), you would be able to do so meaningfully and would be able to demonstrate evidence to this effect	X	N/A
If you intend to engage your community in the design and planning of a subsequent Full Application (if invited), you would be able to do so meaningfully and would be able to demonstrate evidence to this effect	X	N/A
Your team adheres to the requirements of the *French Language Services Act*, as applicable, in serving Ontario's French language communities	X	N/A
If your team is proposing to be responsible for geography that includes one or more First Nation communities you will be able to demonstrate support or permission of those communities[2]	X	N/A

Self-Assessment Scale for Patient Partnership & Community Engagement
Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons

O-O-O-O-O-O-O-O-O-X

Your team is able to meet fewer than 3 of the requirements of above

Your team is able to meet all of the requirements above

[1] *Examples include presence of a Patient and Family Advisory Council within each partner organization, reporting to senior leadership (CEO or Board) to provide direction on strategic issues; inclusion of patient partners on key committees, including hiring committees; patient experience is a key focus for each partner organization with defined targets for meeting/exceeding patient experience metrics. This list is provided for example only and is not exhaustive.*
[2] *For a map of First Nations communities and reserves, please refer to the following link:: https://www.ontario.ca/page/ontario-first-nations-maps*

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

We are committed to a "co-design" approach to our Health Team that meaningfully engages patients, families, caregivers, a broad array of partners, and the communities we serve. We will deliver on these commitments by:

1. **Embedding patients in governance:**

Grounded in our core principle of patient centricity, two patient representatives are Co-chairing the Hamilton Health Team Steering Committee.

2. **Expanding reach across diverse communities**

In order to support a co-design approach for Hamilton's Health Team, we will:

- Draw upon our partnership's network of Patient/ Family Advisors to work with us in co-design
- Engage the broader community leveraging Hamilton Anchor Institution Leadership (HAIL), which comprises Hamilton's largest public and private sector members (**Appendix G**)
- Expand membership to include community social support agencies that service our populations, initially prioritizing agencies that service Year 1 populations
- Address social determinants and health inequities in the longer term

3. **Engaging First Nations and Francophone Communities**

Core to our plan is the meaningful inclusion of Hamilton's First Nations communities – the Six Nations of the Grand River, the Mississaugas of the Credit First Nation, and the urban Indigenous community. With the Aboriginal Health Centre as a Steering Committee member and our partnerships with nearby reserves, we have a strong foundation of meaningful partnership to build on. Our team is committed to culturally appropriate care and the goals of truth and reconciliation.

We are also committed to ensuring we have the capacity to serve Hamilton's Francophone community. Our proposed membership includes four French language service providers.

Model Component 3: Defined Patient Population

At maturity, Ontario Health Teams will be responsible for meeting all health care needs of a population within a geographic area that is defined based on local factors and how patients typically access care.

[illegible]	Yes	[illegible]
Your team is able to identify the population it proposes to be accountable for at maturity	X	N/A
Your team is able to identify the target population it proposes to focus on in Year 1	X	N/A
Your team is able to define a geographic catchment that is based on existing patient access patterns	X	N/A
You know how you will track (e.g., register/roster/enroll) the patients who receive services from your team in Year 1	X	N/A
Of your Year 1 target population, you are confident that you will be able to deliver integrated care to a high proportion of this population and can set an achievable service delivery volume target accordingly	X	N/A

Self-Assessment Scale for Defined Patient Population
Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons

O-O-O-O-O-O-O-O-O-X

Your team is able to meet fewer than 3 of the requirements of above

Your team is able to meet all of the requirements above

Rationale (300 words maximum)

Please provide a rationale for your self-assessment response.
In addition, please include in your response

- *Who you would be accountable for at maturity – describe the proposed population and geographic service area that your team would be responsible for at maturity. Include any known data or estimates regarding the characteristics of this population, such as size and demographics, specific health care needs, health status (e.g. disease prevalence, morbidity, mortality), and social determinants of health that contribute to the health status of the population.*
- *Who you would focus on in Year 1 – describe the proposed target population and geographic service area that your team would focus on in Year 1. Include any known data or estimates regarding the characteristics of this population and explain why you have elected to focus on this population first.*
- *Note: Based on patient access patterns and the end goal of achieving full provincial coverage with minimal overlap and transitions between Ontario Health Teams, the Ministry will work with Teams to finalize their Year 1 target populations and populations at maturity.*

We have brought partners together with a track record of collaboration in serving the needs of Hamilton's population (**Appendix I**). At maturity, our intent is to serve the whole of Hamilton with a population of 551,751. We have a clear picture of the health profiles and geographic zones of our population (**Appendix D, E**).

We are committed to a population health journey that started with many of our partners over two years ago. While we lay the foundation for this longer-term journey, we will focus on two defined population segments:

1. Seniors with multiple chronic conditions; and
2. Individuals with mental health and addictions (child, youth and adult).

We are confident in our ability to redesign care for these defined patient populations for the following reasons:

1. **We understand our population**

In determining our defined patient populations for Year 1, we reviewed population health analysis (**Appendix E**). Key insights include:

- Mental health and addiction is a significant local health burden. Mental illness accounts for 21% of the disability-adjusted life years in Hamilton. Suicide is a leading cause of death for those under 45. Opioid-related deaths tripled from 2005 to 2017.
- Hamilton has had a 23% increase in adults older than 65 years over 10 years and by 2041 will have more seniors than children and youth. Aging is associated with an increase in chronic conditions, functional limitations, health care utilization and sub-optimal outcomes – integration of health and social services is required to proactively support this population.

2. **We have access to data to support ongoing analysis and performance measurement**

One of our biggest assets in supporting a population approach is our Integrated Decision Support (IDS) Data Warehouse (**Appendix F**). This system already houses data from hospitals, home and community care, Community Health Centers and primary care from one Family Health Team.

Model Component 4: In Scope Services

At maturity, Ontario Health Teams will provide a full and coordinated continuum of care for all but the most highly-specialized conditions to achieve better patient and population health outcomes as needed by the population.

Please indicate if your team can meet the following requirements	Yes	No	Partial
Your team is able to deliver coordinated services across at least three sectors of care[3] and you have adequate service delivery capacity within your team to serve the care needs of your proposed Year 1 target population (e.g. your team includes enough primary care physicians to care for all Year 1 patients)	X		
You are able to propose a plan for phasing in the full continuum of care over time, including explicit identification of further partners for inclusion	X		
As part of that plan, you can specifically propose an approach for expanding your team's primary care services to meet population need at maturity	X		N/A

Self-Assessment Scale for In Scope Services
Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons

O-O-O-O-O-O-O-O-O-X

Your team is able to meet fewer than 3 of the requirements of above

Your team is able to meet all of the requirements above

[3] *Prioritization will be given to submissions that include a minimum of hospital, home care, community care, and primary care (including physicians and inter-professional primary care models, such as family health teams, community health centers, and other models that feature a range of inter-disciplinary providers)*

Rationale (300 words maximum)

Please provide a rationale for your self-assessment response.

We are committed to building a future where our services include health promotion, prevention and wellness, as well as integrated services across the continuum of care. We plan to go beyond the minimum Year 1 criteria of coordinated access across three sectors by:

1. **Connecting care across nine sectors:**

Our partners bring the capacity and experience needed to successfully coordinate care for our Year 1 populations. Year 1 in-scope services include:

- Acute care (SJHH, HHS)
- Home and community care support services, including housing (Aboriginal Health Centre, Alzheimer Society, City of Hamilton, SE Health, SJHC, Thrive)
- Mental health and addictions care (Aboriginal Health Centre, Community Mental Health and Addiction agencies, SJHH and HHS, Hamilton FHT)
- Health Promotion and Disease Prevention (City of Hamilton)
- Interprofessional Primary care (Aboriginal Health Centre; HFHT and MFHT serve 300,000 patients)
- Long-term care (City of Hamilton, St. Joseph's Villa, Thrive)
- Rehabilitation and Complex Care (HHS, SJHH)
- Palliative Care (HHS, SJHH, Hamilton FHT, SE Health, SJV Margaret's Place (open 2020))
- Paramedic services (including community paramedicine)

2. **Building upon successful integrated care initiatives**

We intend to leverage all existing care coordinators in the HNHB LHIN, as well as the successes of the ICC program and Hospital to Home program, to design new longitudinal, integrated care bundles.

3. **Growing our base of partners**

Going forward, we intend to phase in all patient populations and create pathways to meet their unique needs. We will continue to expand and engage a full array of health and social services providers in Hamilton.

We have begun community engagement through meeting with the CSS and LTC Network and have also engaged a small network of the largest Community Mental Health agencies in Hamilton who are signatories on this document.

In addition to your scoring rationale, please identify the services you propose to provide to your Year 1 population. For each checked service, you must have adequate service delivery capacity within your team to serve the care needs of your proposed Year 1 target population (e.g. to check off 'primary care physicians' your team must include enough primary care physicians to care for your Year 1 population). Where relevant, provide additional detail about each service (e.g. which member of your team would provide the service).

X	Primary care (Interprofessional primary care)
X	Primary care (Physicians)
X	Secondary care (e.g., in-patient and ambulatory medical and surgical services (includes specialist services)
X	Home care and community support services
X	Mental health and addictions
X	Health promotion and disease prevention
X	Rehabilitation and complex care
X	Palliative care (e.g. hospice)
X	Residential care and short-term transitional care (e.g. in supportive housing, long-term care homes, retirement homes)

X	Emergency health services
X	Laboratory and diagnostic services
	Midwifery services; and
X	Other social and community services and other services as needed by the population (please provide more details below): - Housing (City of Hamilton, Aboriginal Health Centre, several community mental health providers) - Employment supports (City of Hamilton) - Transportation (City of Hamilton)

Model Component 5: Leadership, Accountability and Governance

At maturity, Ontario Health Teams will be self-governed, operating under a shared vision and working towards common goals. Each Team will operate through a single clinical and fiscal accountability framework.

Assess your team's ability to meet the following requirements	Yes	No	Partial
You have identified your partners and at least some partners on your team are able to demonstrate a history of formally working with one another to advance integrated care	X		
You are able to propose a plan for physician and clinical engagement and ensuring inclusion of physician and clinical leadership as part of the team's leadership and/or governance structure(s)	X		
Your team is committed to:			
The vision and goals of the Ontario Health Team model	X		N/A
Putting in place a strategic plan or direction for the team, consistent with the Ontario Health Team vision	X		N/A
Reflecting a central brand	X		N/A
Working together towards a single clinical and fiscal accountability framework	X		N/A
Entering into formal agreements with one another	X		N/A

Self-Assessment Scale for Leadership, Accountability and Governance
Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons

O-O-O-O-O-O-O-O-O-X

Your team is able to meet fewer than 3 of the requirements of above

Your team is able to meet all of the requirements above

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

We are committed to meeting the challenge of designing a governance model that drives system accountability, promotes continuous improvement, and is flexible to adapt as our team matures. Our commitment to one another as partners is outlined in our project Charter (**Appendix A**). We will work towards these commitments by:

1. **Building upon the trust and shared commitment of our partners**

The Hamilton Anchor Institution Leadership (HAIL) comprises Hamilton's largest public and private sector members: the City, EMS, SJHH, HHS, the LHIN, school boards, post-secondary institutions, Hamilton Police, and others (**Appendix G**). HAIL represents a collective commitment to connect institutions across sectors to solve challenges.

Our team will build on the past two years' work of the Hamilton Community Health Working Group (**Appendix H**). The Group sets the vision and priorities for community health in Hamilton and drives relationship development across sectors. This collaboration is evidence that health and social leaders in Hamilton have experience governing a population health program.

Additional examples of the effective inter-agency partnerships in Hamilton are outlined in **Appendix I.**

2. **Embedding Clinicians (including primary care) in leadership**

Our team is committed to embedding clinical leadership within its governance structure, evidenced by the inclusion of Hamilton's largest FHTs in our steering committee and the Primary Care Interface Committee (**Appendix J**). In Year 1 we will build a family medicine coalition representing the care of 100,000 patients in Hamilton. This coalition will serve as a strong voice and partner for clinical co-design and integration within the OHT.

Model Component 6: Performance Measurement, Quality Improvement, and Continuous Learning

At maturity, Ontario Health Teams will provide care accordingly to the best available evidence and clinical standards, with an ongoing focus on quality improvement. A standard set of indicators aligned with the Quadruple Aim will measure performance and evaluate the extent to which Teams are providing integrated care, and performance will be publically reported.

Assess your team's ability to meet the following requirements	Yes	No	Partially
Your team can demonstrate that it has a basic understanding[4] of its collective performance on key integration metrics	X		
Each member of your team as a demonstrated history of quality and performance improvement	X		
Your team has identified opportunities for reducing inappropriate variation and implementing clinical standards and best available evidence	X		N/A
Your team is committed to:			
Collecting, sharing, and reporting data as required	X		N/A
Working to pursue shared quality improvement initiatives that integrate care and improve performance	X		N/A
Engaging in continuous learning and improvement, including participating in learning collaboratives	X		N/A
Championing integrated care at a system-wide level and mentoring other provider groups that are working towards Ontario Health Team implementation	X		N/A

Self-Assessment Scale for Performance Measurement, Quality Improvement, and Continuous Learning

Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons

O-O-O-O-O-O-O-O-O-X

Your team is able to meet fewer than 3 of the requirements of above

Your team is able to meet all of the requirements above

[4] *Each partner collects/reports data for and knows its own performance on at least some of the given metrics (or other similar metrics)*

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response. Identify any shared indicators that are currently being measured or monitored across the members in your team.

We understand that quality and continuous improvement is an important principle for delivering integrated care. We will drive this by:

1. **Continuing to measure and report on key integration metrics**

Our partners bring experience collectively tracking key integration metrics including patient experience, ED visits and readmissions and bed days saved.

As we scale ICC and Hospital to Home, we will track a set of experience and outcome metrics, supported by an expanded patient registry on IDS, which tracks patient level data. As we onboard patients, IDS will continue to drive evidence based collaboration at patient and population health levels.

2. **Scaling quality improvement work focused on reducing variation**

We will expand on the standardized care and variation reduction work ongoing by homecare clinical teams which involves developing standardized clinical pathways for defined patient populations. Clinical teams review care pathways and associated quality indicators (e.g., ED readmissions) to identify successes and opportunities for improvement, and redesign to drive better outcomes.

Year 1 will focus on standardizing system access and navigation for our priority populations. A standard referral form will be developed, followed by expanded common care pathways with associated KPIs.

We will also leverage our history of quality and performance improvement (**Appendix K**).

3. **Expanding access to best practice**

We will leverage the expert research resources in Hamilton to inform and advise on current and future practice including McMaster University's Population Health Research Institute, SE Health Research, Centre for Health Economics and Policy Analysis and GERAS Centre for Aging Research.

Model Component 7: Funding and Incentive Structure

At maturity, Ontario Health Teams will be prospectively funded through an integrated funding envelope based on the care needs of their attributed patient populations. Teams that exceed performance targets will be able to keep a portion of shared savings. Teams will gain-share among members.

Assess your team's ability to meet the following requirements	Yes	No	Partial
Each partner in the team is able to demonstrate a strong track record of responsible financial management[5] (this may include successful involvement in bundled care and management of cross-provider funding)	X		
Your team can demonstrate that it has a basic understanding of the costs and associated cost drivers for your Year 1 population and/or the proposed population at maturity	X		
Your team is committed to:			
Working towards an integrated funding envelope and identifying a single fund holder	X		N/A
Investing shared savings to improve care	X		N/A

Self-Assessment Scale for Funding and Incentive Structure
Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons

O-O-O-O-O-O-O-O-O-X

Your team is able to meet fewer than 3 of the requirements of above

Your team is able to meet all of the requirements above

[5] *Examples of evidence that may suggest poor or declining financial management include: For hospitals – Balanced budget waivers due to deficit, operating pressures request history, cash advance request history, deteriorating working funds position, demonstrated difficulty in managing cross-provider funding as part of bundled care. For primary care (physician and non-physician models) – Non-compliance with their current contract, service accountability agreement and applicable public service procurement practices.*

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response.

Our team is committed to working towards a funding solution that drives value for money while incentivizing better patient experience and outcomes. We will achieve this by:

1. **Building upon experience with bundled care models**

Both HHS and SJHH participated in the provincial pilot for Integrated Funding Models. The findings of this successful program included cost savings for COPD/CHF care at 60 days of over $3,200 per patient. SE Health has implemented award-winning bundled programs with Trillium Health Partners which has resulted in decreased post-operative hospital length of stays.

2. **Continuing to manage funds appropriately and reinvest savings to improve care**

Our team's partners have a history of balanced budgets, strong credit ratings, and a track record of strong financial management and performance.

A key component of the ICC bundle design was the creation of a framework to guide the sharing of gains and losses according to likely scenarios. The success of this model is a testament to the trust, transparency and shared commitment of each member organization to advance on a risk sharing funding model.

3. **Making needs-based funding decisions informed by a strong understanding of our population**

Through population segmentation analysis, we have developed a clear picture of the health profiles and geographic zones of our top 5% care utilizers (**Appendix D**), and what behaviors and conditions drive their costs. Our understanding of high users led to our decision to select patients our Year 1 target populations.

Model Component 8: Digital Health

At maturity, Ontario Health Teams will use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience.

Assess your team's ability to meet the following requirements	Yes	Not	Partial
Most partners in the team have existing digital health capabilities that are already being used for virtual care, record sharing and decision support	X		
Your team is able to propose a comprehensive plan to improve information sharing and resolve any remaining digital health gaps, consistent with provincial guidance regarding standards and services	X		
Your team can identify a senior-level single point of contact for digital health	X		

Self-Assessment Scale for Digital Health
Please indicate your degree of readiness on the following scale using the radio buttons. There is no numerical value assigned to the scale or buttons

O-O-O-O-O-O-O-O-O-X

Your team is able to meet fewer than 2 of the requirements of above

Your team is able to meet all of the requirements above

Rationale (250 words maximum)

Please provide a rationale for your self-assessment response. Identify any common digital tools currently in use by the members of your team

We are committed to working with the province to develop a long-term digital health roadmap that builds upon local innovation and proven solutions, and leverages provincial investments in key digital health assets. In Year 1, however, we propose to begin expansion of existing digital health solutions and capabilities to meet our short-term objectives.

We will meet this commitment by:

1. **Expanding information sharing**

- IDS tracks patient level data across providers and caresettings to increase care providers' understanding
- ClinicalConnect provides physicians and clinicians with real-time access to electronic medical information across integrated services

2. **Providing virtual care options**

- SMArTVIEW combines remote automated monitoring, and virtual hospital-to-home care, education and recovery self-management
- OTN partnerships with SJHH and HHS support eVisits and eConsults linked to OHIP billing
- SJHH virtual care pilot supports virtual visits for patients with their clinicians
- Livecare is a platform for practioners to offer virtual care to improve access, timeliness, integration and experience

3. **Giving patients access to their information**

- MyDovetale gives patients, families and caregivers the opportunity to view health information, message with their care team, video conference, and request, view and cancel appointments
- MyChart is an integrated Patient Portal that allows data access and management

4. **Leveraging strong digital health leadership**

The Hamilton Health Team steering committee includes strong, internationally-recognized leadership in digital health. We will strike a unified digital health secretariat who will drive the evolution and expansion of the aforementioned programs.

Other examples of digital health assets can be found in **Appendix F.**

Part III: Implementation Snapshot

Please provide a high-level overview (maximum 500 words) of how you plan to implement the Ontario Health Team model and change care for your proposed Year 1 target population. Include in your response:

- *Considering the quadruple aim, standard performance measurement indicators, and Year 1 Expectations for Early Adopters set out in the Ontario Health Teams Guidance for Health Care Providers and Organizations, what are your immediate implementation priorities?*
- *What would you anticipate as key risks to successfully meeting Year 1 Expectations and how would you address them?*

The Hamilton Health Team's priority will be to formulate an interim governance model that aligns the appropriate agencies to support implementation work streams.

Our goal for Year 1 is to create an integrated care path -- including seamless transitions from acute to community care – by developing a new model of care coordination inclusive of social and community care supports. Further outreach will be required to engage additional agencies, clinicians, patients, caregivers and community members in the co-design and implementation plans.

We will work towards managing patient care in the community and eradicating hallway medicine by bridging and scaling two evidence-based models of care pioneered in Hamilton: The Bundled Care Model (ICC) and the Hospital to Home Model (H2H).

Initial activities to support the creation of a new longitudinal bundled care framework are:

- Leverage IDS and expertise of the HAIL Data Integration Committee to refine and expand existing models for patient identification, prioritizing patients at highest risk for readmission to the ED
- Build on existing partnerships with front-line responders (e.g. COAST, MCRT, community paramedicine) and housing
- Shift from "coordinated care planning" to a more robust and expansive *cross sector* approach. Develop "integrated care and social service plans"
- Enable fulsome expansion of virtual care opportunities for patients/providers through existing virtual care technology and other innovative remote monitoring programs. Provider and patient education to support expanded deployment will be prioritized in Year 1
- Expand existing 24/7 and one number to call supports for targeted populations
- Build on existing partnerships with primary care through existing tables
- Continue expansion of Hamilton's community-based Transitional Bed Program to support hospital patients with unmet needs while reducing ALC days

The key risks that will require mitigation in Year 1 are :

1. Inability to build interoperable clinical viewers that all care team providers and patients can access. We recognize this will require creative solutions however we are confident in the strong digital health leadership across our partnership, world-leading virtual care adoption, and solid track record of success in collaboration with leading industry partners.
2. Difficulty coordinating and aligning the network of social and community resources and agencies involved with priority populations. Substantive engagement and communication strategies will be required and our health team is committed to investing the necessary time and resources to build fulsome partnerships and relationships.

3. Legislative, regulatory and policy frameworks may be preclusive to some strategies including those involving long-term care and services funded outside of the MOHLTC. Strong partnerships with government partners will be required to identify and remove barriers.
4. Difficulty moving integration metrics in Year 1 will be addressed by implementing a common scorecard using existing shared quality indicators across care team to track performance and report outcomes

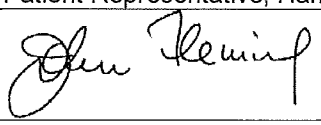
We will leverage our existing change management capabilities to drive the successful implementation of these priorities. This will include building coordinated back-end infrastructure to support scaling of virtual care and integrated electronic patient records. Project management capacity will be needed to support the innovators, providers and clinicians who will lead this work.

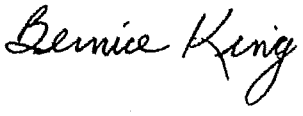
Ontario Health Team Self-Assessment
Hamilton Health Team

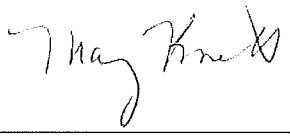
Part IV: Sign Off

Proposed name of the Ontario Health Team	Hamilton Health Team
Primary contact for this application	**Name:** John Fleming
	Title: Co-Chair
	Organization: Patient Representative, Hamilton Health Sciences
	Email: [redacted]
	Phone: [redacted]

Please have every provider or organization listed in Part I sign this form. While Board approval is not required due to the short timeframe of the Assessment process, participants are expected to confirm the highest level of commitment possible.

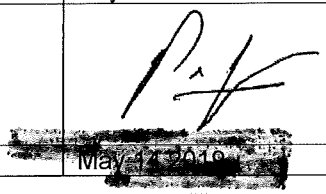
Endorsed by	
Name	John Fleming
Position	Co-Chair, Steering Committee for Hamilton Health Team
Organization	Patient Representative, Hamilton Health Sciences
Signature	
Date	May 14, 2019

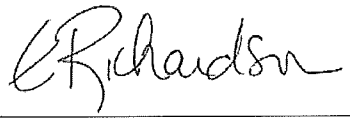
Endorsed by	
Name	Bernice King
Position	Co-Chair, Steering Committee for Hamilton Health Team
Organization	Patient Representative, St. Joseph's Healthcare Hamilton
Signature	
Date	May 14 2019

Endorsed by	
Name	Mary Burnett
Position	Chief Executive Officer
Organization	Alzheimer Society Foundation of Brant Haldimand Norfolk Hamilton Halton
Signature	
Date	May 14 2019

Endorsed by

Ontario Health Team Self-Assessment
Hamilton Health Team

Name	Paul Johnson
Position	General Manager, Healthy and Safe Communities
Organization	City of Hamilton
Signature	
Date	May 14 2019

Endorsed by	
Name	Elizabeth Richardson
Position	Medical Officer of Health
Organization	City of Hamilton
Signature	
Date	May 14 2019

Endorsed by	
Name	Constance McKnight
Position	Executive Directior
Organization	De dwa da dehs nye>s Aboriginal Health Centre
Signature	
Date	May 14 2019

Endorsed by	
Name	Terry McCarthy
Position	Executive Director
Organization	Hamilton Family Health Team
Signature	
Date	May 14 2019

Endorsed by	
Name	Rob MacIsaac
Position	Chief Executive Officer
Organization	Hamilton Health Sciences
Signature	
Date	May 14 2019

Endorsed by	
Name	Dr. David Price
Position	Professor and Chair
Organization	1) Department of Family Medicine, Faculty of Health Sciences, McMaster University, 2) McMaster Family Health Team
Signature	
Date	May 14 2019

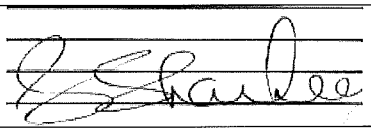
Endorsed by	
Name	Mike McGillion
Position	1) Assistant Dean of Research 2) Scientist
Organization	1) School of Nursing, McMaster University 2) Population Health Research Institute
Signature	
Date	May 14 2019

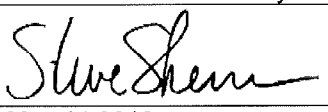
Endorsed by	
Name	Ed Brown
Position	Chief Executive Officer
Organization	Ontario Telemedicine Network
Signature	
Date	May 14 2019

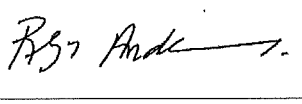
Endorsed by	
Name	Tom Stewart
Position	Chief Executive Officer
Organization	St. Joseph's Healthcare Hamilton
Signature	
Date	May 14 2019

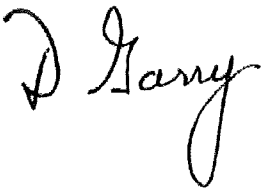
Endorsed by	
Name	Shirlee Sharkey

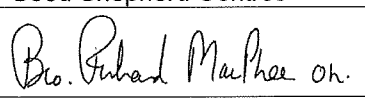
Ontario Health Team Self-Assessment
Hamilton Health Team

Position	Director
Organization	Saint Elizabeth Health Care
Signature	
Date	May 14 2019

Endorsed by	
Name	Steve Sherrer
Position	Chief Executive Officer
Organization	Thrive Group (AbleLiving Services, Capability Support Services, St. Peter's Care Centres and Idlewyld Manor)
Signature	
Date	May 14 2019

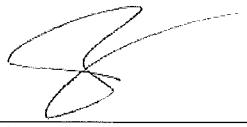
Endorsed by	
Name	Regan Anderson
Position	Chief Executive Officer
Organization	Wayside House of Hamilton
Signature	
Date	May 14 2019

Endorsed by	
Name	Daljit Garry
Position	Chief Executive Officer
Organization	Wesley Urban Ministries
Signature	
Date	May 14 2019

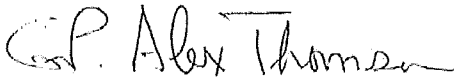
Endorsed by	
Name	Brother Richard MacPhee
Position	CEO
Organization	Good Shepherd Centres
Signature	
Date	May 14 2019

Ontario Health Team Self-Assessment

Hamilton Health Team

Endorsed by	
Name	Jeff Neven
Position	Executive Director
Organization	Indwell
Signature	
Date	May 14 2019

Endorsed by	
Name	Sue Phillips
Position	Executive Director
Organization	Canadian Mental Health Association – Hamilton Branch
Signature	
Date	May 14 2019

Endorsed by	
Name	Alex Thompson
Position	Executive Director
Organization	Lynwood Charlton Centre
Signature	
Date	May 14 2019

List of Appendices:

Appendix A – Hamilton Health Team Project Charter

Appendix B – Integrated Comprehensive Care program briefing

Appendix C – Hospital to Home program briefing

Appendix D – Top 5% of care utilizers

Appendix E – Population health analysis

Appendix F – Digital health asset catalogue

Appendix G – Hamilton Anchor Institution Leadership (HAIL) News briefing

Appendix H – Hamilton Community Health Working Group Project program briefing

Appendix I – Inter-agency partnerships in Hamilton

Appendix J – The Primary/Acute Care Interface Committee briefing and terms of reference

Appendix K – Quality and performance improvement initiative catalogue

Appendix L – HITS eHealth Office letter of support