

Hamilton Health Team: Application Highlights

Hamilton Context

The Hamilton Health Team (HHT) grew from the strong collaboration and leadership in health care that is well established in this city. Since 2016, a formalized group of health and social service providers, named The Hamilton Community Health Working Group (HCHWG) which was born out of Hamilton's Anchor Institution Leadership Group (HAIL), has been working together to examine how to improve health and well-being of the population in Hamilton through better coordination of services – with a view to making patient care experiences more seamless and integrated.

Hamilton Health Team (HHT)

The HHT is co-chaired by two patient advocates, and includes representation across more than 20 organizations, representing primary care, home care, hospitals, community agencies, long-term care, mental health, Indigenous health, post-secondary education, and the City of Hamilton Healthy & Safe Communities Department, Public Health and Paramedic Services. Together, these organizations care for some of the community's most complex and vulnerable patients. Organizational partners and collaborators include:

- Alternatives for Youth
- Alzheimer Society of Brant, Haldimand Norfolk, Hamilton Halton
- Dr. Bob Kemp Hospice
- Canadian Mental Health Association – Hamilton
- Catholic Children's Aid Society of Hamilton
- Centre de santé communautaire Hamilton Niagara
- City of Hamilton (Healthy & Safe Communities, Public Health)
- Compass Community Health
- De Dwa Da Dehs Nye>s Aboriginal Health Centre
- Department of Family Medicine, McMaster University
- Good Shepherd Centres
- HNHB LHIN
- Hamilton Children's Aid Society
- Hamilton Family Health Team
- Hamilton Health Sciences
- Indwell
- Lynwood Charlton Centre
- McMaster Family Health Team
- McMaster University, School of Nursing
- Ontario Telemedicine Network
- Patient Representatives (co-chairs)
- St. Joseph's Healthcare Hamilton (St. Joseph's Home Care, St. Joseph's Villa)
- SE Health
- Thrive Group
- Wayside House of Hamilton
- Wesley Urban Ministries

HHT Engagement

During the past three months, the HHT has hosted a series of workshops designed to build relationships and co-design the application with expertise from health and social service leadership across the continuum of care including patient advisors, public health, primary care providers, community organizations including health, social services, and housing. Trust and relationships were built around a common vision of meeting the Quadruple Aim of improving healthcare delivery in a way that is truly patient-centred, improving population health, and caring for the well-being of providers while efficiently using resources. In total, more than 200 leaders, community members, patients, and physicians participated in this collaborative work to reach consensus and push the boundaries of how health care could be re-designed. This works sets the path for increasing engagement and collaboration into the future. More information on this process can be found here: www.hamilton.ca/OntarioHealthTeam.

Patient involvement

Patients, families and caregivers are considered co-designers and partners. Two patient representatives co-chaired the HHT Steering Committee, helping to ensure that patients and families remained at the forefront. Fifteen patient, family and caregiver participants contributed to the workshops and a representative was a part of all working groups. The model of patients as partners is embedded in the process application and future design of the HHT.

Hamilton Health Team Year 1 Focus

Vision

A healthier community that provides an equitable and seamless continuum of care that actively improves population health and meets the individual needs of our community. A population that is:

- Healthier, with lower rates of chronic illness;
- Activated, informed, and empowered to navigate the system; and
- Treated equitably.

Hamilton Health Team Priority Populations

The following populations were identified through the Community Health Working Groups, primary care and hospital data and in consultation with the community. These populations are well documented and align with the community health issues identified in the Hamilton Spectator's Code Red Series.

- ✚ Adults with mental health and addiction concerns
- ✚ Children and youth with mental health and addiction concerns
- ✚ Older Adults with multiple chronic conditions

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 deaths tripled from 2005 to 2017.

Seniors with multiple chronic conditions: By 2041, Hamilton will, for the first time, have more seniors than children and youth. Providing integrated care for our complex seniors will help ensure this population receives services in more appropriate settings, achieving outcomes aligning with their goals.

Approach to Redesigning and Better Connecting Care

The focus will be to build a new approach to patient care focused on improving patient outcomes and the patient experience by redesigning how to connect, coordinate, and deliver health and community support services to better serve specific populations. Interventions will be focused in three areas:

- **Early identification:** develop a proactive system of care that identifies concerns early and intervenes before issues/illness begin to take hold.
- **Geographic cluster:** A place-based approach in areas where strengthened service coordination and service delivery will make a significant impact on the health of populations and health care utilization.
- **Transitions from hospital:** seamless transitions from hospitals for patients with complex mental illness and addiction conditions and seniors with chronic conditions.

Year 1 Goals:

The intent is to improve outcomes not only for the highest *current* users of healthcare, but over the longer term, to prevent patients from becoming high users. Goals for Year 1 include:

Reduce frequency of ED visits for care that could be provided in the community by establishing a mobile, multi-sector transition team for high users transitioning from hospital;

Reduce 30-day inpatient readmission rates through more effective transition planning and connecting/reconnecting patients to wrap-around services from home and community care providers;

Increase the percentage of patients who had a virtual encounter in the last 12 months through our targeted expansion and improvement of successful digital platforms that offer virtual care;

Improve the rate of post-discharge follow up by primary care within 7-days of discharge by working with the transition teams at our hospitals, and aided by the embedding of LHIN care coordinators in primary care.

Building on Success

The Hamilton Health will build on existing programs and successes in the following areas:

Primary Care Engagement

- Continuing to engage with the two largest Family Health Teams in Hamilton (McMaster FHT and Hamilton FHT) which have provided significant support in development of the plan and will continue to provide support through implementation and collaboration by physicians and providers within their teams.
- Leveraging leadership of a broader network of organizations providing primary care with expertise in Indigenous, francophone, refugee and shelter health.
- Further engaging with a broader spectrum of primary care physicians across the community.

Integrated Patient Care Initiatives

- Integrating and better coordinating of health and social services (housing, long-term care, in-home support services) to proactively support this population.
- Expanding on integrated care delivery success such as the Hospitals 2 Home initiative, and Integrated Comprehensive Care success that has been shown to reduce emergency department visits, hospital readmissions, and the number of patients in Alternate Level of Care and most importantly improve overall patient outcomes and satisfaction.

Digital Solutions

- Leveraging virtual care solutions to improve access for targeted patient populations, including Mental Health and Addiction.
- Expanding remote monitoring for complex older adults post-discharge.

Six focused working groups developed the full submission:

- Governance
- Digital
- Child and Youth Mental Health and Addictions
- Adult Mental Health and Addictions
- Older Adults with Multiple Chronic Conditions
- Home and Community Care

Governance

The interim leadership structure that was put in place to prepare the submission will continue into Year 1 and be further developed. All levels of the HHT governance structure will continue to include health system leaders, physicians and clinician leaders, and patient participants. As teams evolve, governance and leadership structures will evolve to address the needs of the HHT, member organizations, and community. Four distinct groups will carry the governance forward:

Executive Committee: support timely decision making and performance monitoring

Partnership Council: drive overall vision and direction

Oversight and Coordination Secretariat: support the project management office and manage process

Working Groups: develop specific plans related to Year 1 goals

Continuing care for all

Alongside of the work of the HHT, member organizations and service providers are committed to pursuing strategic initiatives to improve the health and well-being of everyone living in our community.

Timeline

Submission Deadline: October 9, 2019

Selection of Ontario Health Team Candidates: Fall 2019