Introduction
Thank you for your interest and effort to date in becoming an Ontario Health Team.

Ontario Health Teams will help to transform the provincial health care landscape. By building high-performing integrated care delivery systems across Ontario that provide seamless, fully coordinated care for patients, Ontario Health Teams will help achieve better outcomes for patients, improved population health, and better value for the province.

Based on the evaluation of Self-Assessment submissions, your team has been invited to submit a Full Application, which is the next stage of the Ontario Health Team Readiness Assessment process.

In the Self-Assessment stage, your team collectively assessed its ability to meet the minimum readiness criteria to become an Ontario Health Team, as set out in ‘Ontario Health Teams: Guidance for Health Care Providers and Organizations’ (Guidance Document). This Full Application builds off the Self-Assessment. In this stage, your team is being asked to propose plans and provide detailed evidence of what you previously assessed that you could do.

This application form consists of seven sections and two appendices:

1. About your population
2. About your team
3. How will you transform care?
4. How will your team work together?
5. How will your team learn and improve?
6. Implementation planning and risk analysis
7. Membership Approval
Appendix A: Home & Community Care
Appendix B: Digital Health

The form is designed to provide reviewers with a complete and comprehensive understanding of your team and its capabilities and capacity. The questions in this form are aligned to the eight components of the Ontario Health Team model and the corresponding minimum readiness criteria set out in the Guidance Document. For any readiness criteria in the Guidance Document that referenced:

- your ability to propose a plan, you are now asked to provide that plan;
- a commitment, you are asked to provide evidence of past actions aligned with that commitment; and
a demonstrated track record or ability, you are asked to provide evidence of this ability.

Please read and fully respond to the questions. Clear, specific responses and the use of verifiable examples and evidence are encouraged.

Note that a core component of the Ontario Health Team model is alignment with the Patient Declaration of Values for Ontario, as well as comprehensive community engagement. This form includes discrete questions related to patient partnership and community engagement, but your team is also encouraged to consider patient, family and caregiver perspectives and opportunities for patient partnership and community engagement throughout your submission.

The Readiness Assessment process will be repeated until full provincial scale is achieved. The first group of Ontario Health Team Candidates will help set the course for the model’s implementation across the rest of the province. Although the core components of the model will remain in place over time, lessons learned by these initial teams will help to refine the model and implementation approach and will provide valuable information on how best to support subsequent teams. The first Ontario Health Team Candidates will be selected not only on the basis of their readiness and capacity to successfully execute the model as set out in the Guidance Document, but also their willingness to champion the model for the rest of the province.

Applications will be evaluated by third-party reviewers and the Ministry of Health (the Ministry or MOH) according to standard criteria that reflect the readiness and ability of teams to successfully implement the model and meet Year 1 expectations for Ontario Health Team Candidates, as set out in the Guidance Document.

Following evaluation of the Full Application there are two possible outcomes. Teams will either: 1) be invited to move to the final stage of evaluation, or 2) continue to work towards readiness as a team ‘In Development’. Those teams that are evaluated as being most ready to move to the final stage of evaluation may also be invited to participate in community visits, which will then further inform the final selection of the first cohort of Ontario Health Team Candidates.

Information to Support the Application Completion

Strengthening the health care system through a transformational initiative of this size will take time, but at maturity, Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a defined population of Ontario residents, and will be accountable for the health outcomes and health care costs of that population. Identifying the population for which an Ontario Health Team is responsible requires residents to be attributed to care providers and the method for doing so is based on
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analytics conducted by ICES. ICES has identified naturally occurring networks of residents and providers in Ontario based on an analysis of existing patient flow patterns. These networks reflect and respect the health care-seeking-behaviour of residents and describe the linkages among residents, physicians, and hospitals. An Ontario Health Team does not have to take any action for residents to be attributed to their Team. As per the ICES methodology:¹

- Every Ontario resident is linked to their usual primary care provider;
- Every primary care physician is linked to the hospital where most of their patients are admitted for non-maternal medical care; and
- Every specialist is linked to the hospital where he or she performs the most inpatient services.

Ontario residents are not attributed based on where they live, but rather on how they access care which is important to ensure current patient-provider partnerships are maintained. However, maps have been created to illustrate patient flow patterns and natural linkages between providers which will help inform discussions regarding ideal provider partnerships. While Ontario Health Teams will be responsible for the health outcomes and health care costs of the entire attributed population of one or more networks of care, there will be no restrictions on where residents can receive care. The resident profile attributed to an Ontario Health Team is dynamic and subject to change over time as residents move and potentially change where they access care.

To help you complete this application, your team will be provided information about your attributed population.

Based on resident access patterns and the end goal of achieving full provincial coverage with minimal overlap between Ontario Health Teams, the Ministry will work with Teams over time to finalize their Year 1 target populations and populations at maturity.

**Participation in Central Program Evaluation**

To inform rapid cycle learning, model refinement, and ongoing implementation, an independent evaluator will conduct a central program evaluation of Ontario Health Teams on behalf of the Ministry. This evaluation will focus on the development and implementation activities and outcomes achieved by Ontario Health Team Candidates and a selection of teams In Development. Teams are asked to indicate a contact person for evaluation purposes.

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Additional Notes

- Details on how to submit your application will be provided by the Ministry.
- Word limits are noted for each section or question.
- Up to 20 pages of additional supplementary documentation are permitted; however, supplementary documentation is for informational purposes only and does not count towards the evaluation of applications.
- To access a central program of supports coordinated by the Ministry, please visit: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/default.aspx or reach out to your Ministry point of contact.
- The costs of preparing and submitting a Self-Assessment and a Full Application or otherwise participating in this Ontario Health Team Readiness Assessment process (the “Application Process”) are solely the responsibility of the applicant(s) (i.e., the proposed Ontario Health Team members who are signatory to this document).
- The Ministry will not be responsible for any expenses or liabilities related to the Application Process.
- This Application Process is not intended to create any contractual or other legally enforceable obligation on the Ministry (including the Minister and any other officer, employee or agency of the Government of Ontario), the applicant or anyone else.
- The Ministry is bound by the Freedom of Information and Protection of Privacy Act (FIPPA) and information in applications submitted to the Ministry may be subject to disclosure in accordance with that Act. If you believe that any of the information that you submit to the Ministry contains information referred to in s. 17(1) of FIPPA, you must clearly mark this information “confidential” and indicate why the information is confidential in accordance with s. 17 of FIPPA. The Ministry would not disclose information marked as “confidential” unless required by law.

In addition, the Ministry may disclose the names of any applicants for the purposes of public communication and sector awareness of prospective teams.

- Applications are accepted by the Ministry only on condition that an applicant submitting an application thereby agrees to all of the above conditions and agrees that any information submitted may be shared with any agency of Ontario.
Key Contact Information

<table>
<thead>
<tr>
<th>Primary contact for this application</th>
<th>Name: Jeff Wingard</th>
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<tbody>
<tr>
<td></td>
<td>Title: Project Director</td>
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<tr>
<td></td>
<td>Organization: Hamilton Health Team</td>
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<td></td>
<td>Email: <a href="mailto:jeff.wingard@hamiltonhealthteam.ca">jeff.wingard@hamiltonhealthteam.ca</a></td>
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<tr>
<th>Contact for central program evaluation</th>
<th>Name: Jeff Wingard</th>
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<tr>
<td></td>
<td>Title: Project Director</td>
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<td>Email: <a href="mailto:jeff.wingard@hamiltonhealthteam.ca">jeff.wingard@hamiltonhealthteam.ca</a></td>
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<td>Phone:</td>
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1. About Your Population

In this section, you are asked to provide rationale and demonstrate your understanding of the populations that your team intends to cover in Year 1\(^2\) and at maturity.

Note: Based on patient access patterns and the end goal of achieving full provincial coverage with minimal overlap between Ontario Health Teams, the Ministry will work with Teams to finalize their Year 1 populations and populations at maturity.

1.1. Who will you be accountable for at maturity?

Recall, at maturity, each Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a attributed population of Ontario residents, and will be accountable for the health outcomes and health care costs of that population.

Your team will be provided with information about its attributed population based on most recent patient access and flow data. These data will include attributed population size, demographics, mortality rates, prevalence of health conditions, utilization of health services by sector, health care spending data, etc.

Also, recall that in your Self-Assessment, your team proposed a population to care for at maturity.

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\(^2\) ‘Year 1’ is unique to each Ontario Health Team and refers to the first twelve months of a team’s operations, starting from when a team is selected to be an Ontario Health Team Candidate.
Below, please rate the degree of alignment between the population and service area that your team originally proposed during the Self-Assessment and your team’s attributed population (high, moderate, low). Where alignment is moderate or low, please explain why your initial proposed population may have differed.

Considering given information about your attributed population and any other data sources you may have, what opportunities and challenges (both in Year 1 and longer-term) does your team foresee in serving and being accountable for your attributed population as you work towards maturity? In your response, reflect on whether your team has experience implementing a population health approach or if this is a competency that will need to be developed. Note: If there is discrepancy between the given information about your attributed population and data that your team has, please comment on the difference below.

**Maximum word count: 1000**

In our Self-Assessment, we proposed that our Hamilton Health Team (HHT) population would align with the geographic boundaries for the City of Hamilton. Our proposed population was based on several factors, including formal service boundaries for several of our key partners (including the City of Hamilton’s Emergency Medical Services (EMS) and Public Health Services), recommendations from our consultations with stakeholders, a deep understanding of the health data within these boundaries, and a history of focusing on this geography within the Hamilton Community Health Working Group and the Hamilton Anchor Institution Leadership group. The population we proposed within our Self-Assessment is moderately aligned with our attributed population.

We do not believe that the moderate alignment will affect our Year 1 populations or accompanying integrated care models. We are confident that as we work toward Maturity, we will have the ability to scale our models, build and enhance relationships, and expand services; however, we do anticipate some challenges associated with providing care to our attributed population.

In our attributed population, we will be responsible for only 78% (approximately 444,000/570,000, current year) of people living in the City of Hamilton and over 170,000 people living outside of the City. As such, this will add a layer of complexity to both the planning and delivery of services at Maturity for individuals within Hamilton who are attributed to other OHTs, and for individuals who live outside of some of our organizational boundaries. More specifically, we anticipate the following challenges as we work toward Maturity:

(1) The attributed population has a substantially higher rural population than we had anticipated. The inclusion of the vast majority of Haldimand County as well as West Lincoln, Lincoln, Wainfleet, Grimsby, and other surrounding areas will require a focused outreach and communications effort to connect with people living in these
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communities around their health needs.

(2) The attributed population has only moderate alignment with some of our member organizations. For example, the City of Hamilton is a founding member of the HHT, and provides EMS, Public Health planning and programs, as well as a range of income and social supports. Going forward, we will require additional data on the Hamilton residents who are not included in our attributed population when planning for integrated services and ensuring all residents have access to required services where they live. Additionally, some integrated care models will be difficult to plan for due to current boundaries of municipal services, including emergency medical services (e.g. Hamilton EMS does not serve Haldimand County).

(3) Monitoring data trends will be somewhat more difficult with our attributed population. Our Self-Assessment demonstrated that one of our major strengths as an HHT was our understanding of the Hamilton population through detailed data collection and analysis. These efforts will need to be expanded through to Maturity to capture data on our attributed population.

(4) As outlined in Questions 1.3 and 3.7, there are challenges in including some members of First Nations Reserves (the Mississaugas of the Credit and the Six Nations of the Grand River) into the HHT attributed population. Our HHT members have strong relationships with De dwa da dehs nye>s Aboriginal Health Centre, and several of our members provide services on reserves, but deepening those partnerships will take some time to develop. Ensuring the autonomy of the First Nations Reserves in planning for improving health outcomes is an important component of success in this regard.

Through our proposed integrated care models, experience with population health approaches, and planned expansion of membership and services, we believe we can support the attributed population that has been ascribed to us. We will continue to liaise with the Ministry of Health (the Ministry) regarding the most effective and efficient deployment of our health care resources in light of the differences between our proposed population and our attributed population.

1.2. Who will you focus on in Year 1?
Over time, Ontario Health Teams will work to provide care to their entire attributed population; however, to help focus initial implementation, it is recommended that teams identify a Year 1 population to focus care redesign and improvement efforts. This Year 1 population should be a subset of your attributed population.

To support the identification of Year 1 areas of focus, you will be provided with information about your attributed population including health status and health care spending data.
Describe the proposed population that your team would focus on in Year 1 and provide the rationale for why you’ve elected to focus on this population. Include any known data or estimates regarding the characteristics of this Year 1 population, including size and demographics, costs and cost drivers, 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.

If this Year 1 population differs from the one you proposed in your Self-Assessment, please provide an explanation.

Maximum word count: 1000

In our Self-Assessment, we committed to redesigning care to ensure integration across providers and sectors for Older Adults with Multiple Chronic Conditions (MCC) and Individuals with Mental Health and Addictions (MHA) concerns. These populations were selected as our target for Year 1 because:

- Over the last 10 years, Hamilton has had a 23% increase in older adults and by 2041, we will have more seniors than children and youth. Aging is often associated with an increase in chronic conditions and functional limitations which may lead to increased health care utilization, sub-optimal health outcomes, and poor patient experiences. Integration of both health and social services is required to reactively and pro-actively support this population.
- MHA is also a significant local health burden in our community. 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 2005-2017. Strengthened and integrated health and social services for this population is also essential with significant increases in prevalence and mortality over the last few years.

We used our Integrated Decision Support (IDS) data repository (Appendix B-2.4.) to identify and better understand the health needs of individuals who were in our Year 1 target populations. A population health analysis of IDS data for both populations enhanced our understanding of their current health utilization and demographics. As a result, we committed to redesigning care for the highest service users of acute care, or ‘high users’ in our Self-Assessment. In our Full Application we have refined our criteria further to describe the populations who we will target in Year 1:

Older Adults with MCC
- Definition: Patients >50 years with ≥2 MCC, and ≥1 acute admission and ≥4 hospital encounters (e.g. emergency department (ED) visits)
- Size: 5957
- Top 5 Diagnoses: Congestive heart failure; Chronic obstructive pulmonary disease with no respiratory infection; Lower urinary tract infection; Chronic obstructive pulmonary disease with respiratory infection; Viral/unspecified pneumonia.
MHA Adults
- Definition: Patients ≥18 years with ≥1 admission and ≥4 encounters in hospital related to MHA
- Size: 1750
- Top 5 Diagnoses: Mental and behavioural disorders due to psychoactive substance use; Schizophrenia and delusional disorders; Mood (affective) disorders; Neurotic, stress-related and somatoform disorders; Poisoning by drugs, medicaments, and biological substance (overdose included).

MHA Child and Youth
- Definition: Patients <18 years with ≥2 hospital encounters with ≥1 acute admission related to MHA
- Size: 2272
- Top 5 Diagnoses: Symptoms and signs involving emotional state, Acute bronchitis, Fever, Asthma, Depressive episode.

(Note: data sourced from IDS, CY2018; diagnoses defined as most responsible diagnosis on last clinical admission)

Additional Insights on ‘High Users’

Older Adults with MCC:
While the diagnoses listed above are the most common single diagnosis, additional data from IDS shows that 24% of these patients have ≥10 chronic conditions, 29% have 7-9, 32% have 4-6, and 15% have 2-3 chronic conditions. There are also overlaps between these adults and the populations for whom care is most costly, including: 1) patients with dementia (and other co-morbidities), 2) patients who are palliative (acute), and 3) patients with skin ulcers with significant co-morbidities (1). This analysis shows the complexity of these cases, and the need for care that is integrated across primary, acute, home, and community services, as well as the need to pay special attention to the impact of dementia and palliative cases. Finally, we will also consider the needs of the caregivers who are supporting this population.

Adults with MHA:
MHA diagnoses and return visits figure prominently in our care redesign, including expanding Rapid Access Addiction Medicine (to address top diagnoses 1,5) and a mobile wrap-around team and digital health opportunities to support transitions between hospital, primary, home, and community care to improve outcomes for MHA top diagnoses 2 to 4. Additional care details provided in Section 3.

Children and Youth with MHA:
The prominence of issues related to mental health in the top diagnoses for children and youth supports increased attention and intervention to support families and children with emerging mental health issues. Additional care details provided in
Profile of Target Population by Geography:
IDS allows our HHT to analyze ‘high users’ (the highest current users of health care resources within hospitals), by geography, which showed that these patients are not equally distributed across the City of Hamilton. When examined by municipal ward (15 total), the ward with the lowest number of Older Adult with MCC high users (109) was much lower than the ward with the highest number of high users (517). The trend was similar with Adults with MHA; one ward had 25 high users, while the ward with the most had 324. The geographic disparity has led our HHT to propose a place-based integrated care model to support and improve the health and wellbeing of residents within these identified areas. This approach is further described in Section 3. Additionally, consultations with stakeholders identified social determinants of health, especially income, stable housing, and employment, have a major impact on both Older Adults with MCC and individuals with MHA. Substantial work has demonstrated these social determinants of health are more prevalent in some neighbourhoods in Hamilton than others – generally aligning with those with high users.

While we understand that our data currently focuses on our proposed population, we are committed to working with the Ministry and our stakeholders to better understand our attributed population, and expand membership and services from Year 1 to Maturity.

Baseline Data:
The HHT will have strong baseline data options to measure change over time. While the HHT attributed population aligns moderately with our proposed population, our ability to monitor change year over year with Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) sub-region data (percent unscheduled repeat ED visits for mental health or substance use, rate of ED visits best managed elsewhere, 30 day unplanned re-admission rates), IDS data sets (high users, change over time), and individual health outcomes will equip us to monitor performance and continuously improve.

1.3. Are there specific equity considerations within your population?
Certain population groups may experience poorer health outcomes due to socio-demographic factors (e.g., Indigenous peoples, Francophone Ontarians, newcomers, low income, other marginalized or vulnerable populations, etc.). Please describe whether there are any particular population sub-groups within your Year 1 and attributed populations whose relative health status would warrant specific focus.

Maximum word count: 1000

Where known, provide information (e.g., demographics, health status) about the following populations within your Year 1 and attributed populations. Note that this
information is not provided in your data support package. LHIN Sub-Region data is an acceptable proxy. Other information sources may also be used if cited.

- Indigenous populations
- Francophone populations
- Where applicable, additional populations with unique health needs/status due to socio-demographic factors

Within both our Year 1 and attributed populations (using the City of Hamilton as a proxy for our attributed population), there are particular population sub-groups whose relative health status warrants specific focus, including an Indigenous population, Francophone population, and materially-deprived populations.

Indigenous Population:
Hamilton is located next to Six Nations of the Grand River, the most populous Indigenous reserve in Canada. The 2016 Census counted 12,130 Indigenous Hamiltonians, but research shows that over 80% of urban Indigenous do not participate or identify themselves in the Census (2). Therefore, Hamilton’s Indigenous population may be as high as 24,000 to 48,000. An Indigenous designed and led innovative survey entitled Our Health Counts, interviewed 790 Indigenous Hamiltonians finding 78% earn less than $20,000 annually, 69% receive social assistance, 57% of adults have not completed high school, and 1 in 8 reported being homeless or living in precarious housing (3). Each of these social determinants of health (income, employment, education, and housing) contributes substantially to poor health outcomes (4).

Our Health Counts also found that Hamilton’s Indigenous population faces significantly higher rates of infectious and chronic diseases and, thus are likely over-represented among Year 1 Older Adults with MCC (3). For example, diabetes rates are 3 times greater and Hepatitis C rates are 10 times greater among urban Indigenous people compared to the general population. Among our Year 1 population of Adults with MHA, Indigenous people are likely to be similarly over-represented. Substance use was more frequently reported among Hamilton’s urban Indigenous with 87% currently smoking tobacco, 19% reporting misuse of prescription opioids, and 55% reporting heavy drinking episodes (twice the rate of our general population in Hamilton). Mental health was also a major concern with 42% of urban Indigenous reporting a psychological or mental disorder diagnoses by a healthcare provider. Over 1 in 10 urban Indigenous people (10.6%) are frequent users of the emergency department (>5 visits per 24 months) which is 7 times greater than the Hamilton average of 1.6%. In 2018, a Hamilton community survey found that 22% of people surveyed experiencing homelessness in Hamilton identified as Indigenous (5).
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Francophone Population:
As of the 2016 Census, Hamilton is home to 6,760 Francophones, while 30,530, or nearly 6% of the population, speak both English and French (6). Compared to other Francophone age groups, language retention rates are highest among seniors (7). Research and evidence based studies are unequivocal: language and culture are essential determinants of health for the minority population and may be the most important determinant of health for this population (8).
The HHT recognizes that the engagement of the Francophone communities needs to be more systematic, and include patient/client, caregiver, advisor, and other stakeholder’s voices. To ensure that the needs of the Francophone population are better captured throughout the continuum of care, an environmental scan of the needs, gaps, and capacity within our community will be used to develop HHT strategies and solutions to better meet the needs of the Francophone community.
The engagement of the local French Language Health Planning Entity (Entité 2) is at its infancy but will continue throughout the process of establishing and operating the HHT. A French Language Services (FLS) lens will be embedded in all HHT Working Groups to ensure that engagement is not done in isolation of FLS planning.

Social Determinants of Health and Materially-Deprived Populations:
Hamilton has one of the highest concentrations of urban poverty within Canada (6). Material deprivation is the inability of individuals to afford or attain basic material needs, for example, deprivation of income, employment, education, and housing. In comparison to the general population, individuals who are materially-deprived are more likely to experience negative outcomes including being more likely to die from infections, cancer, circulatory disease, respiratory disease, suicide, and substance overdoses. More specifically, individuals within this population subgroup are more likely to experience:
- Premature Death: Hamiltonians living in areas with the highest material deprivation are 3-times more likely to die prematurely from an avoidable cause compared to the least materially deprived populations in our city. This disparity is among the highest in Ontario and this gap is widening. Hamiltonians in the most deprived areas lived 14 years less than those living in the most affluent areas (9). The Hamilton Spectator’s Code Red series on health inequities found a 21 year difference in life span across Hamilton’s 130 neighbourhoods (10).
- Mental Health: Hamiltonians living in areas with the highest material deprivation are 3-times more likely to visit an emergency department for mental health care compared to the least materially deprived populations in our city. This disparity is among the highest across urban centres in Ontario (9).
- Social Isolation/Disability/Mental Well-being: In some of Hamilton’s social housing buildings (where up to 80% of tenants come from homelessness or
precarious living), high concentrations of social isolation and mental health challenges are observed, including: 54% report being diagnosed with a mental illness, 35% report depression, 32% report anxiety, 31% report changes to mental wellness, 33% struggled with addictions, 31% report asthma or chronic obstructive pulmonary disease (COPD), 56% report living with a disability, 54% receive Ontario Disability Support Program (ODSP) income support, and 50% report multiple chronic conditions (9). In addition, 1 in 5 tenants are socially isolated and the rate of ED visits for mental health conditions is 6.5-times higher than the average city rate (11).

-Suicide & Substance Overdose: Hamiltonians living in the most materially-deprived neighbourhoods are 2-times more likely to die from suicide and 5-times more likely to die from a substance overdose.

-Drug Use: A Hamilton survey of people who inject drugs found that 25% were Indigenous, 20% reported living on the street in the past 6 months, 76% earned less than $20,000 per year, 51% collected ODSP income support and 37% collected Ontario Works income support (12).
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2. About Your Team
In this section, you are asked to describe the composition of your team, what services you are able to provide, the nature of your working relationships, and the approach you used to develop this submission.

2.1. Who are the members of your proposed Ontario Health Team?
Please complete the tables below identifying the proposed physicians, health care organizations, and other organizations (e.g., social services) that would be members of the proposed Ontario Health Team.

Note:
- In Year 1, Ontario Health Team Candidates will have an agreement in place with the Ministry outlining their responsibilities as a team, including service delivery and performance obligations. Organizations and individuals listed as Ontario Health Team members in tables 2.1.1 and 2.1.2 would be party to this agreement and are expected to deliver services as part of their team. If there are organizations who intend to collaborate or be affiliated with the Ontario Health Team in some way but would not be party to an agreement with the Ministry (e.g., they will provide endorsement or advice), they should be listed in section 2.5. Note that a Year 1 agreement between an Ontario Health Team Candidate and the Ministry is distinct from any existing accountability agreements or contracts that individual members may have in place.
- Generally, physicians, health care organizations, and other organizations should only be members of one Ontario Health Team, unless a special circumstance applies (e.g., provincial organizations with local delivery arms, provincial and regional centres, specialist physicians who practice in multiple regions, etc.).

2.1.1. Indicate primary care physician or physician group members
Note: If your team includes any specialist (i.e., secondary care or GP-focused practice) physicians as members, please also list them and their specialty in this table. The information in this table will be used to assess primary care representation and capacity/coverage.

<table>
<thead>
<tr>
<th>Name of Physician or Physician Group</th>
<th>Practice Model</th>
<th>Number of Physicians</th>
<th>Number of Physician FTEs</th>
<th>Practice Size</th>
<th>Other</th>
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</table>

4 Physician practice models include: Solo Fee for Service (Solo FFS), Comprehensive Care Model (CCM), Family Health Group (FHG), Family Health Network (FHN), Family Health Organization (FHO), Blended Salary Model, Rural and Northern Physician Group (RNPG), Alternate Payment Plans. Family Health Teams may also be listed in Table 2.1.1. Community Health Centres, Aboriginal Health Access Centres, Nurse Practitioner Led Clinics, and Nursing Stations should be listed in Table 2.1.2. If you are unsure of where to list an organization, please contact the MOH.
<table>
<thead>
<tr>
<th>Provide the name of the participating physician or physician group, as registered with the Ministry.</th>
<th>Please indicate which practice model the physician(s) work in (see footnote for list of models)</th>
<th>For participating physician groups, please indicate the number of physicians who are part of the group</th>
<th>For participating physician groups, please indicate the number of physician FTEs</th>
<th>If the listed physician or physician group works in a practice model that is not listed, please indicate the model type here.</th>
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</thead>
<tbody>
<tr>
<td>Mixed or provider-led Family Health Teams and their associated physician practice(s) should be listed separately. Where a Family Health Team is a member but the associated physician practice(s) is/are not, or vice versa, please note this in the table. Physician groups should only be listed in this column if the entire group is a member. In the case where one or more physician(s) is a member, but the entire group practice is not, then provide the name of the participating</td>
<td></td>
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<td>Note here if a FHT is a member but not its associated physician practice(s). Also note here if a physician practice is a member by not its associated FHT (as applicable).</td>
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2.1.2. Indicate member organizations (not including physician(s)/physician groups)

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<thead>
<tr>
<th>Name of Organization</th>
<th>Type of Organization</th>
<th>LHIN/Ministry Funding Relationship</th>
<th>Primary contact</th>
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<tr>
<td>Provide the legal name of the member organization</td>
<td></td>
<td>Does the member organization have an existing contract or accountability agreement with a LHIN, MOH, or other ministry? If so, indicate which</td>
<td>Provide the primary contact for the organization (Name, Title, Email, Phone)</td>
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</table>

See supplementary Excel spreadsheet

2.2. How did you identify and decide the members of your team?
Please describe the processes or strategies used to build your team’s membership. Are there key members who are missing from your team at this point in time? Are there any challenges your team sees in moving forward with respect to membership?

In your response, please reflect on whether your team is well positioned to care for your Year 1 and maturity populations. Identify any strategic advantages your team has in relation to the health and health care needs of your Year 1 and maturity populations.

Max word count: 500

HHT membership was built on early successes in improving health and social services in our community. Over three years ago (and prior to the OHT opportunity), leaders in Hamilton’s health and social service community formed the Hamilton Community Health Working Group (HCHWG). The HCHWG met regularly to identify creative and innovative ways to deliver integrated, improved, and accountable care across organizational boundaries. HCHWG membership included system leaders, patients, and community members from the core sectors of an OHT model (Primary, Acute, Home, Community Care, and Broader Community Services). This group of providers brought the experience, reach, scope of services, and track record of

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5 Indicate whether the organization is a Health Service Provider as defined under the Local Health System Integration Act, 2006 (and if so what kind—hospital, long-term care home, etc.), Community Support Service Agency, Service Provider Organization, Public Health Unit, Independent Health Facility, Municipality, Provider of Private Health Care Services, Other: Please specify
partnership to integrate care across multiple settings. Using the HCHWG as our foundation, we have formed our HHT Partnership Council which includes organizations, clinicians, specialists, family doctors, and health and social service providers – including housing and first responders -- from across multiple sectors that will position us to provide a full continuum of care for our Year 1 and attributed populations. We have also established a key role for Patients, Families, and Caregivers in the structure and work of our Partnership Council, including 2 patient co-chairs.

Organizations involved provide a range of services:

**Acute:** St. Joseph’s Healthcare Hamilton (SJHH) and Hamilton Health Sciences Corporation (HHS)

**Home and Community Care:** Alzheimer Society, City of Hamilton, SE Health, St. Joseph’s Home Care, Thrive Group, and in collaboration with De dwa da dehs nye>s Aboriginal Health Centre

**Mental Health and Addictions:** Community Mental Health and Addictions agencies, SJHH, HHS, Hamilton FHT, McMaster FHT, and in collaboration with De dwa da dehs nye>s Aboriginal Health Centre

**Health Promotion and Disease Prevention:** City of Hamilton Public Health Services

**Primary Care:** Hamilton FHT, McMaster FHT, and in collaboration with De dwa da dehs nye>s Aboriginal Health Centre, Community Health Centres (CHC) (Compass CHC and Centre de santé communautaire Hamilton/Niagara)

**Long-Term Care:** City of Hamilton's Macassa and Wentworth Lodge, St. Joseph’s Villa, Thrive Group (St. Peter’s at Chedoke Residence and Idlewyld Manor)

**Rehabilitation and Complex Care:** HHS, SJHH

**Palliative Care:** SJHH, HHS, Hamilton FHT, SE Health, St. Joseph’s Villa, and in collaboration with Dr. Bob Kemp Hospice, Emmanuel House Hospice

**Paramedic Services:** City of Hamilton (including community paramedicine)

**Broader Community Social Services:** City of Hamilton, Good Shepherd Centres, Indwell, Lynwood Charlton Centre, Wayside House, Wesley Urban Ministries, and in collaboration with De dwa da dehs nye>s Aboriginal Health Centre, CHCs (Compass CHC and Centre de santé communautaire Hamilton/Niagara).

Together, we care for some of community’s most complex and vulnerable patients. The Ministry’s new vision for health care delivery will enable us to redesign how we connect, coordinate, and deliver services so that care is patient-centred and connected. We are leveraging our collective experience, passion, and commitment to advance and expand our impact and efforts to create meaningful, patient-centred change for our community and do not foresee any challenges in moving forward with respect to current membership. We continue to collaborate with other organizations with plans for further engagement.
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2.3. Did any of the members of your team also sign on or otherwise make a commitment to work with other teams that submitted a self-assessment?

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Other Affiliated Team(s)</th>
<th>Form of affiliation</th>
<th>Reason for affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>List the other teams that the member has signed on to or agreed to work with</td>
<td>Indicate whether the member is a signatory member of the other team(s) or another form of affiliation</td>
<td>Provide a rationale for why the member chose to affiliate itself with multiple teams (e.g., member provides services in multiple regions)</td>
</tr>
</tbody>
</table>

See supplementary Excel spreadsheet

2.4. How have the members of your team worked together previously?
Please describe how the members of your team have previously worked together in a formal capacity to advance integrated care, shared accountability, value-based health care, or population health (e.g., development of shared clinical pathways or shared patient care, participation in Health Links, Bundled Care, Rural Health Hubs; shared back office, joint procurement; targeted initiatives to improve health on a population-level scale or reducing health disparities).

As part of your response, identify specific initiatives or projects that illustrate the success of your teamwork. Include detail about project scale and scope (e.g., patient reach), intended outcomes and results achieved (including metrics), which team members were involved, and length of partnership. Note: information provided should be verifiable through documentation by request.

Identify which members of your team have long-standing working relationships, and which relationships are more recent. Also identify whether there are any members of the team who have never previously worked with any other members of the team on initiatives related to integrated care, shared accountability, value-based health care, or improvement at the population health level.

Max word count: 2000

Our HHT member organizations and providers have a longstanding history of working together on successful initiatives that have both pioneered and advanced integrated care in our community. Our commitment to work together was born out of our shared visions and goals of creating a patient-centred and integrated health system to support the unique challenges of residents within our community (see Question 1.3.).

As stated previously (Question 2.2), in 2016 the Hamilton Community Health Working Group (HCHWG) began working together to examine how to improve the 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. When the Ministry announced the OHT initiative, the HCHWG recognized the potential and similarity to its work, and the present HHT was able to build on these years of experience.

In addition to being part of a larger formal working group, there are also several examples of our HHT member organizations taking part in successful interagency partnerships. Through these partnerships, our member organizations have provided improved coordinated care to individuals living in our community, including Older Adults with MCC and individuals with MHA concerns. Examples of these partnerships include:

Initiative: Vanier Towers
Organizations: McMaster University, City of Hamilton, HHS, McMaster FHT, Wesley Urban Ministries, SJHH, Mental Health Resource Centre, HNHB LHIN, ODSP, Hamilton EMS, Hamilton Police Services
Description: In recognition of the deep health inequities for the residents of the Vanier Towers Social Housing complex in Hamilton (a social housing complex with >1000 residents located in a materially deprived area), organizations have come together to better understand and address the health issues and underlying barriers to health and wellbeing for these residents. Partners have developed a Vanier Hub of Service which includes many partners providing in-kind social and/or health services. The Hub uses a holistic multi-pronged approach based on the philosophy of building one multi-disciplinary, coordinated team to ensure residents receive consistent and holistic social and health supports.
Outcomes: Improved access to income support; Improved access to Primary Care; Increased perception of safety; Improved perception of health status; Reduction in # of fire, police, and paramedic calls; Reduction in ED visits and readmissions; Reduction in # of admissions to hospital; Improved perception of health status; Reduction in # of fire, police, and paramedic calls; Reduction in ED visits and readmissions; Reduction in # of admissions to hospital.

Initiative: Hospital 2 Home (Health Links Philosophy)
Organizations: HHS, Primary Care, HNHB LHIN, City of Hamilton, various social and community services partners
Description: The Hospital 2 Home (H2H) team is an interdisciplinary team of regulated health professionals partnering with patients to develop coordinated care plans in the community. The H2H team partners with health, social, and community service providers to develop action plans helping patients achieve their goals.
Outcomes: The H2H team has partnered with approximately 1100 patients since 2015 and 12 months post-initiation of care plans achieved 40% fewer ED visits, 51% fewer admissions, 58% fewer 30-day readmissions, 35% fewer admissions for ambulatory-care sensitive conditions, 97% of patients said the team linked them to the health services they needed, 88% of patients said their care plan addressed both their health and social care needs.

Initiative: Integrated Comprehensive Care (ICC) Program
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Organizations: SJHH, St. Joseph’s Home Care, St. Mary’s General Hospital, and Niagara Health
Description: The ICC Program is a patient-centred model of care that uses a bundled funding model to support a seamless patient transition from the hospital to home/community. Throughout the patient’s care journey they have access to one team, one record, and 24/7 access to a clinician supported by virtual care technology.
Outcomes: Cost savings per patient at 60 days is over $3,200. The program has also seen over 98% patient satisfaction, up to 30% reduction in ED visits and readmissions to hospital, and over 30,000 bed days avoided.

Initiative: Transitional Care Beds
Organizations: HHS, SJHH, St. Joseph’s Home Care, HNHB LHIN, Thrive Group Able Living Assisted Living, and local retirement homes.
Description: The Transitional Care program offers an alternative, community-based option for hospital patients who, while ready for discharge from acute care, are unable or not yet able to return home. Professional services such as nursing, occupational therapy and physiotherapy services and personal supports are provided to patients. In Hamilton, there are a total of 137 transitional care beds in operation.
Outcomes: Over 20,000 patient days since 2015, system savings of approximately $9M, successful transitions to home, retirement homes, and long-term care homes.

Initiative: Rapid Access Addiction Medicine Clinic (RAAM)
Organizations: SJHH, HHS, COAST, MASH, WKAS, Connect, community family physicians, Hamilton FHT, McMaster FHT, Shelters, community based addiction programs, community based mental health programs, Police, EMS
Description: The RAAM Clinic was established with support from the Provincial government to combat opioid overdoses. Working with community addiction partners and family physicians it provides patients with an appointment within 24 hours of referral. This service connects patients to evidence-based addiction care and works with them to create a care plan that fits with their goals. The RAAM clinic will diagnose substance use disorders and concurrent mental health disorders, initiate pharmacotherapy when indicated, provide harm reduction interventions and advice, provide brief solution-focused counselling, make appropriate links to community services, link patients back to primary care when stable, or connect patients to primary care providers if unattached.
Outcomes: In less than one year since opening this program, next day ED admissions have been reduced by 60%. To date, 900 patients have been referred. Pre and post measures indicate a reduction in cravings and an increase in one’s confidence level in their ability to maintain changes.

Initiative: Crisis Orphaned Patient Management
Organizations: SJHH, HHS, Maternity Centre of Hamilton, Wesley Urban Ministries, Shelter Health, Youth Wellness Centre, Good Shepherd, McMaster FHT
Description: Agreements have been put in place with a variety of programs and services across Hamilton to provide primary care to orphaned patients when they present to these services and do not have a family physician. Programs and services providing
## Ontario Health Teams
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<table>
<thead>
<tr>
<th>Initiative</th>
<th>Organizations</th>
<th>Description</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted Living HUB model</td>
<td>Thrive Group (AbleLiving, Capability Support Services), HNHB LHIN, City of Hamilton, SJHH, HHS</td>
<td>Thrive Group has developed HUBs in three areas of Hamilton (downtown core, Hamilton mountain, and the border of Aldershot Village and Hamilton). Each HUB provides up to 33 individuals a combination of supported housing units and home environments, with access to support services 24 hours per day. Each HUB works with mid to high acuity level clients with scheduled and unscheduled on demand personal supports and services.</td>
<td>Reduction in ED visits, better coordinated care with home and community providers. Over 90 clients are being served at any given time, overall system savings, coordinated care with home and community support services organizations. Increased fully accessible and affordable housing stock in partnership with the City of Hamilton by renovating existing buildings and increasing the number of supportive housing units in the community.</td>
</tr>
<tr>
<td>Memory Clinics</td>
<td>Alzheimer Society, McMaster FHT, Hamilton FHT</td>
<td>Alzheimer Society staff support the work of the FHTs who assess persons suspected of having a form of dementia and their caregivers.</td>
<td>Individuals connected to the Alzheimer Society earlier in the disease process have better outcomes, improved quality of life.</td>
</tr>
<tr>
<td>Supportive Housing</td>
<td>Indwell, Good Shepherd, City of Hamilton</td>
<td>Indwell and Good Shepherd provide supportive housing to households in Hamilton. The City of Hamilton provides rent subsidies for individuals living at Indwell and Good Shepherd properties where they can access on-site supports. Through partnerships with the Federal and Provincial governments, the City of Hamilton has also provided capital funding to Indwell and Good Shepherd for development projects thereby increasing supply of supportive housing units in our community.</td>
<td>Increased capacity in supportive housing units, including over 320 households supported by Indwell and 550 by Good Shepherd.</td>
</tr>
<tr>
<td>Primary care embedded care managers</td>
<td>HNHB LHIN, Hamilton FHT and McMaster FHT</td>
<td>A standardized evidence-based practice to support patients in the community with an expanded care coordination role. Includes but is not limited to assessment of health literacy, patient action plans, and tools to support warm hand-off/transitions, and connect patients to supportive community services as a member of</td>
<td></td>
</tr>
</tbody>
</table>
the primary care team.
Outcomes: Increased subjective satisfaction of collaboration and services with the Care Managers, Family Physicians and FHT team, patients and their families. Reduced duplication of services. Seamless transitions.

2.5. How well does your team’s membership align to patient/provider referral networks?
Based on analysis of patient flow patterns and the natural connections between providers and patients revealed through this analysis, your team has been provided with information about which patient/provider referral networks the physician and hospital members of your team are part of.

How would you rate the degree of alignment between your current membership and the provider networks revealed through analysis of patient flow and care patterns (high, moderate, low)? Where alignment is moderate or low, please explain why your team membership may have differed. Given the provided data, have you updated your team membership since the Self-Assessment?

Max word count: 500
As reviewed in Question 1.1, our Self-Assessment proposed the geographic boundary of the City of Hamilton as our population at Maturity. This is reflected by our HHT membership (organizations, providers, and collaborators). Thus, the degree of alignment between our current membership and the planned provider networks is moderate.

While the challenges the attributed population creates in terms of service delivery and data analytics are outlined in Question 1.1, the moderate alignment with provider networks creates similar complexities. Several of our partners provide region-wide services and programs (e.g. Alzheimer Society, Indwell, Thrive Group, OTN, SE Health, HHS, SJHS) which give some coverage with regard to provider networks in the more rural areas of our attributed population. However, the corresponding loss of nearly one-quarter of the people who live in the City of Hamilton may impact how population health initiatives are efficiently delivered as we work toward Maturity.

With regard to our Year 1 populations, our team membership continues to be very well matched. Given that Hamilton alone makes up 78% of the total attributed population, it makes sense to focus Year 1 activities on the majority areas and learn from that work. Additionally, given that the Hamilton Anchor Table (data management
across Hamilton institutions) has been working together as partners for the past few years, and understand the health and socio-demographic needs of Hamilton, we are well-poised to have success within Year 1. Based on the Year 1 learnings, it gives time for the HHT to engage other key providers in Haldimand, Grimsby, West Lincoln and Lincoln as we move toward Maturity.

2.6. Who else will you collaborate with?
Please provide information on who else your team plans to collaborate or affiliate with. Describe the nature of your collaboration and include information on any plans to coordinate services with these providers or organizations. If your team has received endorsement from specialist physicians or clinical leaders/leadership structures (e.g., Chiefs of Service, Medical Directors, Medical Advisory Committees), please list them in table 2.6.1.

2.6.1. Collaborating Physicians

<table>
<thead>
<tr>
<th>Name of Physician or Physician Group</th>
<th>Practice Model</th>
<th>Number of Physicians</th>
<th>Collaboration Objectives and Status of Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Describe your team’s collaboration objective (e.g., eventual partnership as part of team) and status (e.g., in discussion)</td>
</tr>
</tbody>
</table>

See supplementary Excel spreadsheet

2.6.2. Other Collaborating Organizations

<table>
<thead>
<tr>
<th>Name of Non-Member Organization(s)</th>
<th>Type of Organization</th>
<th>Collaboration Objectives and Status of Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide the legal name of the collaborating organization</td>
<td>Describe what services they provide</td>
<td>Describe your team’s collaboration objective (e.g., eventual partnership as part of team) and status (e.g., in discussion)</td>
</tr>
</tbody>
</table>

See supplementary Excel spreadsheet

2.7. What is your team’s integrated care delivery capacity in Year 1?
Indicate what proportion of your Year 1 target population you expect to receive integrated care (i.e., care that is fully and actively coordinated across the services that your team provides) from your team in Year 1. Please provide a rationale for this estimate and describe what actions you will take to ensure as many Year 1 patients who
require integrated care will receive it.

Max word count: 500

We are taking a comprehensive approach to providing integrated care that is fully and actively coordinated across the services that our team provides in Year 1. Through this approach, we will focus on providing coordinated reactive and proactive services along the continuum of care to improve access, system navigation, transitions, and coordination of services. This approach will help address the needs of our current high users, while also intervening with individuals before they require acute level resources.

As mentioned in Question 1.2, our target populations for Year 1 include Older Adults with MCC, and Individuals with MHA concerns. To ensure we are able to improve patient outcomes aligned with performance metrics linked to the Quadruple Aim, we have identified segments of these populations where integrated care can make the most impact in Year 1. These segments were identified through analysis of local public health and health services data, reviewing evidence, engaging local experts, providers, and patients. They include:

Improving transitions into, within, and from hospital including ambulatory and specialist care: Older adults with MCC and Individuals with MHA transitioning from hospital.

Early Identification: Individuals with select clinical and/or social indicators (e.g. frailty, social isolation) who will benefit from a proactive system of care and support that identifies and intervenes before they require acute level resources.

Geographic Clusters: Select geographic areas where a place-based integrated care approach (strengthened service coordination and delivery) will make a significant impact on the health of populations, while addressing the social determinants of health. This approach will include several of our HHT members and collaborators working together as a team within a geographic area.

Our segmented approach will allow us to redesign care along the continuum; for patients with complex needs who require both reactive and proactive care (transitions into within and from hospital); early and proactive intervention of individuals who may be at risk of becoming very sick (early identification), and at the population health level through enabling healthy behaviours and activities, and self-care that promotes physical and mental wellbeing (geographic clusters).

Additionally, this approach provides us with the opportunity to co-design both in and out-reach services for our populations that can be scaled through to Maturity. More specifically, through our Early Identification and Geographic Cluster models, we have the opportunity to develop both in-reach services (e.g. proactive services offered to our early identification segment to promote health, prevent disease, and help people live well with their conditions at home) and out-reach services (e.g. proactive services offered to individuals within geographic clusters who may otherwise not access them to help promote health and well-being of the population).
### 2.8. What services does your team intend to provide in Year 1?

Provide a description of each service, indicate whether the service would be available to your entire Year 1 population or a subset (with rationale), and indicate which member of your team will provide the service.

<table>
<thead>
<tr>
<th>Service</th>
<th>Proposed for Year 1 (Yes/No)</th>
<th>Capacity in Year 1 (how many patients can your team currently serve?)</th>
<th>Predicted Demand in Year 1 (of your Year 1 population, how many patients are predicted to need this service)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interprofessional team-based primary care</td>
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<tr>
<td>Physician primary care</td>
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<tr>
<td>Acute care – inpatient</td>
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<tr>
<td>Acute care – ambulatory</td>
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<tr>
<td>Home care</td>
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<td>Community support services</td>
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<td>Mental health and addictions</td>
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<tr>
<td>Long-term care homes</td>
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<tr>
<td>Other residential care</td>
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<tr>
<td>Hospital-based rehabilitation and complex care</td>
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<tr>
<td>Community-based rehabilitation</td>
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<tr>
<td>Short-term transitional care</td>
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<tr>
<td>Palliative care (including hospice)</td>
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<tr>
<td>Emergency health services (including</td>
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</tbody>
</table>

*See supplementary Excel spreadsheet*

*Please complete Appendix A.*
## 2.9. How will you expand your membership and services over time?

At maturity, Ontario Health Teams are responsible for offering a full and coordinated continuum of care. Teams are expected to expand the population they serve each year, working towards providing care for their entire attributed population.

Describe your plan for phasing in the remaining continuum of care for your population, including proposed timelines. Your plan should include explicit identification of further members, collaborators, and services for inclusion for Year 2. Include in your response commentary on whether your team anticipates any challenges in expanding the types of services your team provides or meeting demand for services beyond year 2, given your attributed population.

Max word count: 500

Going forward, we intend to phase in all patient populations and create pathways to meet their unique needs across the continuum of care. As such, we will continue to expand and engage a full array of health and social services providers in our community from Year 1 through to Maturity.

As part of our Year 1 activities, our Governance Working Group is developing criteria for HHT membership, which will include provisions around what each member will provide to the HHT to ensure that we are able to expand our services to meet demand between Year 2 and Maturity, given our attributed population. Our membership criteria will also include specific equity considerations for particular population sub-groups whose relative health status would warrant specific focus. As such, we will prioritize expansion to Indigenous, Francophone, and other health and social service providers in Year 1 through to Maturity. Furthermore, we will ensure membership is expanded equitably across the core sectors of the OHT model to scale integrated care to Maturity.
As membership criteria is established, within Year 1 our Population Working Groups (Older Adults with MCC, MHA) will identify additional members, collaborators, and services for inclusion as they finalize their integrated care models. For example, within our Early Identification segment, we will continue to expand membership to providers who are involved in each patient’s care pathway (where appropriate). This will ensure patients receive all required health and social services that are fully integrated along the continuum of care to keep them healthy at home. Similarly, during the development of population health management strategies for our Geographic Clusters, we will work to identify organizations already providing services in these areas, and include them as HHT members or collaborators as appropriate. By doing so, we will ensure that we are providing systematic coverage and access to both health and social services while also minimizing duplication of services within these geographic areas. This method of care and service delivery, as well as expansion of membership, can be scaled to other geographic areas and populations within our attributed population through to Maturity.

We have also already engaged several organizations and providers who are associated with our Year 1 target populations. As referenced in Question 2.6., several organizations and providers are collaborating with us to provide coordinated services to our Year 1 populations (see Appendix 3). Additionally, the following organizations who provide services to our Year 1 population have expressed interest in becoming involved in our HHT in Year 1: YWCA Hamilton, Mission Services of Hamilton, Hamilton Urban Core CHC, Ontario Palliative Care Network, and French Language Health Planning Entité 2. Once membership criteria is established in Year 1, we anticipate these organizations will become HHT members and the services provided through our HHT will expand to provide and meet demand for services from Year 2 through to Maturity.

If you do not have all primary care providers in your network involved at this point, please describe what efforts have been made to date to involve these providers and your plan for how you will expand primary care partnerships to meet population need at maturity.

Max word count: 500

Our first-wave of primary care members and collaborators included in our HHT are comprised of all primary care providers at the McMaster FHT, a subgroup of primary care providers at the Hamilton FHT, a number of unaffiliated Family Health Organization and Family Health Group physicians, and individual physicians affiliated with Shelter Health, Compass Community Health Centre, and Centre de santé communautaire Hamilton/Niagara. This group represents a significant number of primary care providers in our community.

To expand our partnerships to all primary care providers in our network by Maturity we will include invitations based on patient alignment with defined clinical focus pathways. Our system navigation and care coordination models could be marketed on a trial basis to primary care providers in our network during implementation and initial
years of our HHT. This would allow primary care providers to trial the resources and benefits provided by our HHT prior to signing on as a member.

We will also enlist primary care provider ambassadors who will serve as champions of change to engage their colleagues and promote membership of HHT. In Year 1 we will quickly identify and promote these individuals from within our first wave primary care group and will ensure peer endorsement in the selection of these individuals.

Our growth strategy will be incumbent on the following:

- Committing to working with provincial groups and leveraging their outreach to primary care providers. This includes the Ontario College of Family Physicians, Ontario Medical Association, Nurse Practitioners’ Association of Ontario, Registered Nurses’ Association of Ontario, Alliance for Healthier Communities, Association of Family Health Teams of Ontario, and Indigenous Primary Health Care Council.
- Locally with the strength of our HHT. As our HHT plans align strongly with the Quadruple Aim, including better provider and patient experience, we anticipate additional primary care providers opting in through Year 1 and Maturity.

2.10. How did you develop your Full Application submission?

Describe the process you used to develop this submission. Indicate whether it was an participatory process across all members and if your submission reflects a consensus across the entire membership. If so, describe how consensus was achieved. Indicate whether any third parties external to your team were involved in the completion of this form (e.g., grant writers, consultants).

Also consider in your response:

- If patients, families, and caregivers partnered or were engaged or consulted in the design and planning of this submission, please describe any partnership, engagement, or consultation activities that took place and whether/how feedback was incorporated.
- If your team engaged with the local community in the design and planning of this submission, please describe any engagement activities that took place and whether and how feedback was incorporated. In particular, please indicate whether your team engaged with local Francophone communities (e.g., local French Language Planning Entities) or with Indigenous communities. Describe the nature of any engagement activities with these communities and whether/how feedback was incorporated.
- If you have community support for this application (e.g., support from a municipality), please provide a description and evidence of this support. If your team’s attributed population/network map overlaps with one or more First Nation
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communities [https://www.ontario.ca/page/ontario-first-nations-maps], then support from those communities for your team’s application is required. Where applicable, please indicate whether you have support from First Nation communities. Indicate the nature of the support (e.g., letter of support, band council resolution, etc.). If you do not have support at this time, provide detail on what steps your team is taking to work together with First Nations communities towards common purpose.

Max word count: 1000

HHT Planning Workshops:
Between August and September 2019, facilitated by a primary care physician, the HHT Project Management Team hosted four workshops with over 200 participants representing both patients, and acute, primary, and community care providers. During these workshops we built and strengthened relationships, fostered engagement, redesigned care, and generated content for our full application.
Each workshop consisted of both large group activities and small breakout sessions. The large group activities facilitated collaboration, trust, partnership, communication, and mutual respect across all participants and organizations present. These activities also helped surface large-scale ideas, innovations, and solutions for health and social service delivery.
During our smaller breakout sessions, a number of Working Groups redesigned care for our Year 1 populations. Each Working Group’s membership represented the core sectors of the OHT model to ensure input on redesign was being provided from various sectors in an integrated way.
Members of the Working Groups included front-line physicians and clinicians, staff, academics, French Language Services, and Indigenous organizations, and patient participants with lived experience. The Working Groups aligned with our Year 1 priorities: Older Adults with MCC, MHA Adults, MHA Child and Youth, Home and Community Care, Digital Health, Governance, and Primary Care. Members also worked across Working Groups to ensure our strategies were interconnected.

Building Consensus:
Between workshops, each Working Group worked closely with the HHT Project Management Team to further develop content to be included in the application. The application was approved by each level of our current governance structure and our patient Co-Chairs (Oversight and Coordination Secretariat, Partnership Council, and Executive Sponsors).

Engagement:
Our participatory approach ensured that patients, families, caregivers, and providers developed our plans to actively shape how local services are delivered and managed. We did not engage any third parties external to our team (e.g. consultants) to develop content for our application. Our application was a participatory process across all involved, with heavy reliance on in-kind and volunteer contributions and expertise.

Version Date: 2019-09-11
Community Support from First Nations:
Our attributed population includes First Nations communities, specifically, 4,628 people from New Credit (Mississaugas of the Credit Reserve) and 2,131 people from Six Nations of the Grand River. As described in Sections 1.3 and 3.7.1, several current members of the HHT have partnerships with the Six Nations Reserve. SJHH manages the Six Nations Satellite Hemodialysis Unit, while HHS Regional Cancer Program and the Alzheimer Society have strong partnerships in place. Many secondary and tertiary regional programs are provided by HHT members (e.g. HHS - McMaster Children’s Hospital, trauma, cardiac). The City of Hamilton has developed an Urban Indigenous Strategy. The collaboration with De dwa da dehs nye>s Aboriginal Health Centre in the HHT also provides some context for engaging with both New Credit and Six Nations in terms of how to improve health outcomes. The HHT recognizes that building a relationship with both Reserves will take time, patience, understanding, and dialogue. We look forward to building on our successful partnerships, and engaging with our Indigenous communities in a respectful and culturally sensitive manner.

3. How will you transform care?
In this section, you are asked to propose what your team will do differently.

By redesigning care for their patients, Ontario Health Teams are intended to improve patient and population health outcomes; patient, family, and caregiver experience; provider experience; and value. By working together as an integrated team, Ontario Health Teams are also expected to help improve performance on a number of important health system measures, including:

a) Number of people in hallway health care beds
b) Percentage of Ontarians who had a virtual health care encounter in the last 12 months
c) Percentage of Ontarians who digitally accessed their health information in the last 12 months
d) 30-day inpatient readmission rate
e) Rate of hospitalization for ambulatory care sensitive conditions
f) Alternate level of care (ALC rate)
g) Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
h) Total health care expenditures
i) *Patient Reported Experience Measures, Provider Reported Experience Measures, and Patient Reported Outcome Measures are also under development*
j) Timely access to primary care
k) Wait time for first home care service from community
l) Frequent ED visits (4+ per year) for mental health and addictions
m) Time to inpatient bed
n) ED physician initial assessment
3.1. What opportunities exist for your team to improve care for your population and health system performance in Year 1 and at maturity?

Considering the measures listed above and the health status of your Year 1 and maturity populations, please identify and provide rationale for what your team considers to be your most important (e.g., top three to five) performance improvement opportunities both for Year 1 and longer term. In your response, consider your team’s assets, the services you intend to provide, and the features of your Year 1 and attributed populations. Explain how you identified these priority improvement opportunities and any relevant baseline performance data you have for your Year 1 and/or attributed populations.

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Section 1 of our Full Application outlines patient profiles and care needs of our attributed population, our rationale for choosing our Year 1 target populations, and how we will integrate that work with priority populations including Indigenous people, Francophones, and people living in high-poverty and materially deprived neighbourhoods. Our Year 1 target populations: Older Adults with MCC, Adults with MHA, and Children/Youth with MHA all require specialized integrated and innovative models of care. As Section 1.2 describes, the highest users within these groups are patients with complex care needs who are having multiple encounters with acute care services, including hospital admissions.

Section 2 allowed us to describe the attributes and strengths of our HHT and our capacity to deliver integrated care across a wide variety of services. We have also highlighted the historical partnerships that have created the foundation for our proposed innovative health delivery design that our Full Application articulates.

Acute Care: Both acute care organizations have experience leading new models of integrated care (Hospital 2 Home, Integrated Comprehensive Care, Bundled Care).

Primary Care: The engagement of our two FHTs, with their wide coverage of patients in Hamilton (over 60% of all people in Hamilton), as well as solo primary care practitioners, and collaboration with local Community Health Centres speaks to the genuine interest in working across institutions and sectors to breakdown silos and improve the patient experience.

Community Care: Our community mental health and addiction organizations and supportive housing providers add expertise and capacity to provide much-needed support and service.
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Public Health: Finally, the addition of the City of Hamilton not only brings Public Health and Emergency Medical Services to the HHT, but also many programs (place-based and otherwise) that help to address the social determinants of health, which will broaden the types of care we can offer patients.

Given our Year 1 populations and capacity to provide a variety of health and social services, we have identified an opportunity to provide integrated care and improve the Quadruple Aim metrics for three targeted segments. Thus, our Full Application seeks to align and integrate care in three targeted models in Year 1: (1) Improving transitions into, within, and from hospital; (2) Early Identification; and (3) Geographic Clusters.

This strategic approach will ensure we can properly track the patient experience and measure impact across several key integration metrics and outcomes. Our focus on intervening upstream with the support of HHT Primary and Community Care members will allow us to improve outcomes not only for the highest current users of health care resources (‘high users’), but over the longer term will prevent patients from becoming high users and will contribute to the reduction of hallway medicine in the future.

By redesigning care for our patients and focusing on proactive identification of needs, care coordination across providers and sectors, service navigation and 24/7 access, we will improve patient and population health outcomes, patient, family, and caregiver experience, provider experience, and value, as aligned with the Quadruple Aim.

Additionally, our Year 1 targeted integrated models of care, as discussed further in Questions 3.2. to 3.7., will allow for performance improvement opportunities on the following Ministry of Health key health system metrics for our Year 1 populations. We also anticipate that as we scale our targeted integrated models of care to Maturity, these key metrics will continue to be improved for our attributed population:

(1) Frequent/Avoidable ED visits: In Year 1, through early identification, intervention in primary care and the community, and establishment of a mobile, multi-sector transition team for high users transitioning from hospital, we anticipate that frequent and/or avoidable ED visits for our target population may be reduced due to availability of targeted services within the community.

(2) 30-Day Inpatient Readmission Rates: Through more effective transition planning and links to wrap-around services and targeted place-based services from home and community care providers, we anticipate 30-day readmission rates may be reduced for our Year 1 populations.

(3) 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 (see Appendix B) in partnership with acute, primary, and community sectors, we anticipate additional patients in our Year 1 populations will receive virtual care offerings within Year 1.
(4) 7-day Post-Discharge Primary Care Follow-up: Through inclusion of Primary Care Providers as members and collaborators within our HHT, as well as the primary care based interventions, we anticipate that there will be an increase in the number of patients who receive a follow-up from their primary care provider within 7 days of transitioning from hospital. Working with the transition teams at our hospitals, and aided by the embedding of care coordinators in primary care, this transition will become more seamless, and result in smoother flow of information and follow up.

Baseline Data:
For measures of the Quadruple Aim, we will need to work with the Ministry to establish baseline measures. For Key Metrics 1 and 2, we will use IDS and LHIN sub-region data to both establish a baseline and to measure progress before and after implementation of our Year 1 initiatives. Metric 3 will be monitored by our Digital Health Working Group, while a Metric 4 baseline will rely on LHIN sub-region data for a baseline, coupled with a data tracking tool for Year 1 populations (all described more fully in Question 3.5).

3.2. How do you plan to redesign care and change practice?
Members of an Ontario Health Team are expected to actively work together to improve care for their patients. Please describe how you will work together to redesign care and change current practices in your first 12 months of operations to address the performance improvement opportunities you identified in section 3.1.

In your response, please consider what specific outcomes you’re aiming to achieve, as measured by one or more of the indicators listed above (or others, as relevant), and what targets, if any, you have set from baseline.

Note that detailed commentary on how you propose to provide care coordination and system navigation services, virtual care, and patient self-management are requested in subsequent sections.

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All of the HHT member organizations have a robust track record and ongoing commitment to improving care experiences and health outcomes through integrated-care initiatives that can be incorporated in a comprehensive population-health management approach, including population segmentation, co-design of integrated care and service stratification. As such, we are committed to redesign an integrated system that is patient-centred and addresses the holistic health and social needs of those in our attributed population. As described in Question 2.10., four planning workshops were held with cross representation from over 200 health and social service providers, patients, families and caregivers to develop a common vision for the HHT and redesign care for Year 1 target populations. The resulting integrated care models developed as part of our Year 1 plan are rooted in our core design principles with the ultimate goal to improve the patient and provider experience by focusing on both health and determinants of health, improving transitions,
standardizing care paths, and delivering care as one team. Our vision for Year 1 will be scaled over time and is inspired by a population health approach along the continuum of care, incorporating prevention, promotion, and care. This includes improving transitions into, within, and from hospital including ambulatory and specialist care, early identification, and geographic clusters.

The resulting matrix (see Appendix 1) is a framework that is based in a population health management approach that encompasses not only those utilizing the highest share of health care resources (high users), but also those who are at risk of becoming a ‘high user’, in a way that can be successfully spread and scaled to our full attributed population by Maturity. Our Home and Community Care, Governance, Primary Care, and Digital Health Working Groups will act as enablers for success in Year 1, while also building the HHT’s capacity to meet future service demands and expectations through to Maturity.

More specifically, across these pillars of integrated care models and Year 1 populations, our HHT will re-design care with the intent of changing current practices and achieve the Quadruple Aim through the following:

**HOSPITAL TRANSITIONS (INTO, WITHIN, FROM; INCLUDING AMBULATORY AND SPECIALIST CARE)**

**Older Adults with MCC**

For Older Adults with MCC who are often the highest service users (‘high users’), our work in Year 1 will build on the evidence-based and documented successes of Hospital 2 Home, Integrated Comprehensive Care Model for COPD/Congestive Heart Failure (CHF), and Bundled models of care by:

- Developing a standardized method of identifying and assessing patients who require these models of care across health care sectors, and focusing on the highest service users within our Year 1 population.
- Identifying and realigning resources from health, social, and community care providers to improve access and deliver more coordination across multiple providers and settings to avoid unnecessary ED visits and readmissions.
- Standardizing care plans and aligning efforts across providers focused on the patient’s perspective of ‘what matters most to you’ and ‘what is most important about your health.’
- Supporting patients’ unique needs (including their cognitive ability, isolation, frailty and the social determinants of health) to support their ability to self-manage chronic conditions.
- 24/7 access to support and system navigation.
- Increased virtual care opportunities (e.g. expansion of remote monitoring and other virtual offerings as detailed in Appendix B).
- Exploring opportunities related to ambulatory and specialist care to support integrated care in the right place at the right time.
## Adults with MHA Concerns

In the first 12 months of operations, our Adults with MHA Working Group will redesign care to promote successful transitions into, within and from hospital including ambulatory and specialist care. Due to the anticipated needs of the Year 1 population, this intervention will look slightly different than for the Older Adults with MCC. Our HHT team will provide 24-7 wraparound care at transition from hospital for Adults who are admitted for MHA, or Adults who are admitted for a medical concern but who have MHA comorbidity and are considered a ‘high user’ (4+ ED visits/year). These individuals will also have one point of contact upon discharge to support successful transition from hospital. This team will be mobile, and made up of system navigators and case managers that will provide personalized support, ED diversion, and access to community and supportive housing partners. The team will be supported by the creation of a city-wide bed management system that allows us to identify HHT residential and supported housing beds available in the community in real-time for patients ready to leave hospital requiring these services.

## Children and Youth with MHA Concerns

To help support seamless transitions between hospitals and the community, our Child and Youth MHA Working Group will implement the following initiatives within Year 1 to support Children and Youth with MHA concerns:

- Creation of a patient transition protocol between McMaster Children’s Hospital and St. Joseph’s Healthcare Hamilton to support the transition between pediatric and adult hospital sites for youth currently receiving hospital-based services.
- Support the development of an HHT transitional age youth protocol that addresses the treatment barriers of those at-risk youth with emotional dysregulation and suicidal ideation.

## Hospital Transitions Ministry of Health Key Metrics for Performance Improvement:

- Quadruple Aim
- Frequent/Avoidable ED Visits
- 30-day Inpatient Readmission Rates
- Percentage of Patients who had a Virtual Encounter in the last 12 Months
- 7-day Post-Discharge Primary Care Follow-up

## EARLY IDENTIFICATION

### Older Adults with MCC

In Year 1, we will work with our HHT Primary Care Provider Members/Collaborators to develop an early identification process for Older Adults with MCC. We will focus on two initiatives including:

1. Identifying and intervening where there are Older Adults with MCC who would
benefit from an integrated palliative approach to care; and
(2) Developing an evidence-based approach to identify and intervene with an integrated care pathway for Older Adults with MCC who are at risk of sub-optimal health outcomes, poor experience, and high use of health care resources ('high users'). For example, individuals with cognitive impairments, social isolation, frailty, and/or poverty.

Integrated care models for identified Older Adults with MCC will be comprised of a team including primary care, hospital, home care, and community services. To ensure these initiatives are successful and there are smooth transitions between providers, we also plan to expand on existing pilots to embed LHIN care coordination into our primary care providers' practices and continue to integrate in hospitals (see Question 3.3).

Adults with MHA Concerns

Similar to the Older Adults with MCC population, our Adults with MHA Working Group will develop an early identification process for Adults with MHA Concerns. We will focus on two initiatives including:
(1) Identification and interventions for Adults with MHA who would benefit from a Rapid Access Addiction Medicine (RAAM) model of care; and
(2) Identification and interventions for Adults with MHA who are at risk of becoming high service utilizers due to a select social/clinical indicator identified by HHT Primary Care Providers.

To ensure these initiatives are successful, we will develop a standardized, evidence-based approach to identify individuals who require RAAM across our HHT Primary Care Providers. We will also enhance Primary Care capacity within our HHT to support this work by providing best practice for addiction management training to HHT Primary Care Providers. Additionally, to ensure demand for services within our Year 1 population can be met, we will expand clinical and physician resources at the RAAM to provide services virtually and on a mobile basis.

Similar to the Older Adults with MCC approach, individuals who are identified by HHT Primary Care Providers as having select health and social determinants of health indicators leading to high health care utilization ('high users') will have access to integrated care teams to improve outcomes and improve patient experience.

Children and Youth with MHA Concerns

In Year 1, our MHA Child and Youth Working Group will identify and intervene with children and youth at risk of mental health and or addictions through the following initiatives:
• Expand and scale use of a validated tool and corresponding pathway for young children, 0-6, at high risk, identified in certain city-led programs, child welfare teams, and EarlyON Child and Family Centres.
• Identify children and youth who are at risk of becoming 'high users' by selecting a clinical indicator identified by HHT Primary Care Providers with an evidence-based intervention.
• Expand partnership with Public Health, HHS, SJHH to identify high-risk families prior to hospital discharge postnatally and respond with 24/7 support, one number to call, and increased health and social supports led by a specialized HHT team.

Early Identification - Ministry of Health Key Metrics for Performance Improvement:
- Quadruple Aim
- Frequent/Avoidable ED Visits
- Percentage of Patients who had a Virtual Encounter in the last 12 Months

GEOGRAPHIC CLUSTERS

In Year 1, the Older Adults with MCC and Adults with MHA Working Groups will work together to co-design an integrated service delivery model for identified location(s) where the population is impacted by the social determinants of health such as low income, and experiences sub-optimal health outcomes, poor experience while using a high share of health care resources. The geographic location(s) will be identified using health and social service utilization data and community engagement within the first 30 days of Year 1.

Key components of this initiative include:
• An on-site, relationship-based service advocate model that incorporates care coordination and system navigation with a cross-sector approach to include social services in order to enhance the physical and mental wellbeing of residents;
• Timely access to health care professionals including mental health and addiction supports, warm handoffs and virtual care options;
• Improved efficiencies through coordination of home and community care provision within the geographic cluster.

This work will result in a model of integrated care that optimizes health outcomes and allows people to age in place, reduce isolation, and reduce/delay the need for long-term care, acute care, and emergency medical services (similar to the Vanier Towers project described in Question 2.4.). Working as an integrated team within a geographic cluster will also help us reduce duplication and confusion around services available to health and social care providers. Additionally, this integrated model of care will allow us to document a neighbourhood-level integrated care approach that can be spread and scaled to our attributed population by Maturity. De dwa da dehs nye>s Aboriginal Health Centre, in partnership with several other Indigenous organizations, the City of Hamilton health and social service providers, McMaster Department of Family Medicine, and neighbourhood groups, have proposed a cluster re-development of the former St. Helen’s elementary school in northeast Hamilton as one potential model (see Appendix 2).

Geographic Clusters - Ministry of Health Key Metrics for Performance Improvement:
- Quadruple Aim
- Frequent ED Visits
3.3. How do you propose to provide care coordination and system navigation services?

Seamless and effective transitions, 24/7 access to coordination of care, and system navigation services are key components of the Ontario Health Team model. Care coordination and system navigation are related concepts. Generally, care coordination refers to “deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient” (Care Coordination. Agency for Health care Research and Quality (2018). System navigation activities can include helping people understand where to go for certain types of care and facilitating access to health and social services. Teams are expected to determine how best to implement 24/7 access to coordination of care and system navigation services based on the needs of their patients and which members of the team are best suited to play this role.

3.3.1. How do you propose to coordinate care?

Care coordination is a critical element of high-performing integrated care, particularly for patients who require higher-intensity care. Considering the needs of your Year 1 population, please propose how your team will coordinate care for these patients. In your proposal, describe whether any of the members of your team have experience coordinating care across multiple providers and care settings.

Describe what activities would be in and out of scope for your care coordination service in Year 1. Describe which patients will have access to care coordination services, how they will access the service, and whether care coordination resources will be organized differently from how they are currently deployed in order to better serve your population. Indicate whether your team will coordinate any care beyond the in-scope services provided by your immediate team.

Describe who (i.e., what type of staff, which organization) would provide care coordination, how many existing FTEs would be assigned to this service, and whether your team has sufficient existing capacity to meet the anticipated care coordination needs of your Year 1 population. Please specify if your plan involves the use of LHIN care coordination resources.

Describe how you will determine whether your care coordination is successful.
Our Year 1 goal for care coordination is to build on our members’ experiences and design an improved care coordination vision for our HHT while setting the foundation for care coordination at Maturity.

As the HHT has evolved, the following foundational care coordination principles have been co-designed:
1) Ensure that patients and caregivers are asked ‘what matters most’ to them in their care journey;
2) Move coordination of care closer to patients and their primary care providers;
3) Ensure a seamless continuum that is proactive and provided by the individual coordinating care;
4) Care coordination includes health and social services as one integrated team;
5) Care coordination is flexible and moves with the patients across sectors;
6) Care coordination takes into account the holistic needs of the patient.

Some of Year 1’s work will include understanding current capacity and where there are gaps or redundancies in the care coordination system (see Question 6.1.). The following activities will be completed in Year 1:

1) Determine care coordination activities across partners;
2) Map care coordination activities and complete a gap analysis for services currently provided in our community across sectors (including social services);
3) Ensure care coordination includes a cross-sector planning approach that includes both health and social services;
4) Align and embed current LHIN care coordinators into primary care practices;
5) Continue to integrate LHIN care coordinators with hospital teams.

In addition to the essential starting points above, targeted care coordination activities will occur for our Year 1 populations. These include:

Older Adults with MCC:
(A) Hospital Transitions - Many of our Year 1 high service using older adults with MCC have access to some care coordination services through the hospital. For example, care coordination is a key feature of Hospital 2 Home and ICC. Leverage services with improved home and community care supports to increase the effectiveness and continuity of integrated care plans. The support of the current LHIN care coordinators will serve a crucial function with the high service users being successful once transitioned from hospital. We anticipate supporting these individuals with the support of primary care and home care, while enabling access where appropriate to ambulatory and specialist care.
(B) Early Identification - Care coordination will be a crucial element when identifying at-risk patients in primary and community care settings. Estimating the full amount of care coordination is difficult currently, but is likely to exceed our current capacity. Year 1 will identify any overlap, gaps, and needs while testing this new model.
(C) Geographic Clusters - Our Older Adults with MCC and MHA Adults Working
Groups will initiate a new care coordination model in the geographical cluster Year 1 in partnership. This approach will blend both traditional care coordination with social services and incorporate a social determinants of health lens. Based on similar models (e.g. Vanier Towers), we anticipate care coordinators will support each cluster. We believe these positions can be covered with existing resources.

**Adult MHA:**

(A) Hospital Transitions - The development of a HHT team and 24-7 wrap around services to support identified patients transitioning from hospital will require care coordination to connect with hospital, community, primary care, peer support and residential supportive housing partners. The number of FTE’s required to achieve the desired level of service is yet to be determined, however, we believe these positions can be covered with existing resources.

(B) Early Identification - Care coordination will be a crucial element when identifying at-risk patients in primary and community care settings. Estimating the full amount of care coordination is difficult currently, but is likely exceed our current capacity. Year 1 will identify any overlap, gaps, and needs while testing this new model.

(C) Geographic Clusters - MHA Adult Working Group will work with the Older Adults with MCC Working Group to ensure appropriate care coordination resources are located within selected geographic clusters (see Older Adults with MCC, Geographic Clusters description above)

**Child and Youth MHA:**

(A) Hospital Transitions - It is likely that year 1 high service youth who are transitioning into the adult mental health system will require care coordination activities. In Year 1, we will be identifying overlaps, gaps, and needs for this population, including care coordination resources required.

(B) Early Identification - Care coordination will be a crucial element when identifying at-risk patients in primary and community care settings. Estimating the full amount of care coordination is difficult currently, but is likely exceed our current capacity. Year 1 will identify any overlap, gaps, and needs while testing this new model.

(C) Geographic Clusters - Within our proposed approach for low barrier, walk-in mental health drop-ins for Children and Youth at risk for MHA, we anticipate care coordination can be offered within currently existing resources.

As stated in our Self-Assessment, our HHT committed to leveraging all care coordination currently available through the HNHB LHIN. We propose to continue embedding LHIN care coordinators into primary care practices and integrate the care coordinators with the hospital teams in Year 1. An integral portion of Year 1 work will focus on asset mapping care coordination in Hamilton and completing a gap analysis to understand the capacity in the system and what is needed at Maturity. We are committed to optimizing care coordination and will work with the Ministry through implementation in Year 1 to ensure we have appropriate care coordination resources for our attributed population.

**Measuring Success**
We will evaluate care coordination across our HHT. We will develop measures and indicators to measure success of care coordination in Year 1. Successful care coordination will be defined as:

- Improvement in patient and population health outcomes;
- Seamless transitions across the continuum;
- Patients feeling connected and supported, and the Patient Declaration of Values implemented;
- Improved patient and caregiver experience with care coordination;
- Clarity for patients, their families, and providers with respect to the individual’s care journey;
- Coordination is integrated across all sectors.

3.3.2. How will you help patients navigate the health care system?

Patients should never feel lost in the health care system. They should be able to easily understand their options for accessing care and know where to go for the services they need. Considering the needs of your Year 1 population, please propose how your team will provide system navigation services for your Year 1 population. Describe what activities are in and out of scope for your system navigation service in Year 1. Describe which patients will have access to system navigation and how they will access the service. Indicate whether system navigation will be personalized (e.g., will the system navigator have access to a patient’s health information).

Describe how the system navigation service will be deployed and resourced, and whether your team has sufficient existing capacity to meet the anticipated navigation needs of your Year 1 population.

Describe how you will determine whether your system navigation service is successful.

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Patients need to know next steps in their care journey. Our Year 1 populations require not only the coordination of health services, but the ability to navigate health and social services as their health needs change. Formal system navigation has been demonstrated through various initiatives in our community, including:

- System navigators employed by Family Health Teams
- Navigation provided by Integrated Comprehensive Care (ICC) Coordinators through the ICC program
- Navigation provided by Hospital 2 Home Integrated Care Lead
- Social Navigator program with the Hamilton Paramedic Services

In addition, the following are examples of informal system navigation in community settings, embedded within support positions:

- Addictions workers at the RAAM clinic who help patients book and attend appointments related to health care and addressing social determinants of health;
- The City of Hamilton provides staff that are able to help patients address a range of social determinants of health, including employment, secure housing, child care,
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emergency income;
The Alzheimer Society’s counselling and behavioural supports coordinators help caregivers and families find dementia-specific system resources; and
-Community agencies provide individuals with support in choosing available services appropriate for their needs. These agencies also help individuals access, schedule, travel to, and attend many relevant services.
-Use and improvement of existing shared information sites, such as the HNHB LHIN’s My Health GPS including their single number to call.

Spreading and scaling successful navigation models is one of our priorities for our Year 1 populations to support equitable access services through navigation. Our Year 1 goal is to ensure Year 1 populations have access to system navigation as needed, while creating a new vision for the attributed population at Maturity. Essential system navigation principles will be co-designed and will include the following:

1) System navigation is personalized to meet the needs of the patient;
2) System navigation will be user-friendly for both patients and care providers enabling timely access to health and social services resources; and
3) Patient choice remains the number one priority for navigation.

The in-scope activities for Year 1 include:
-Continuing to spread and scale ICC and Hospital 2 Home models that have demonstrated positive outcomes as a result of system navigation supports;
- Co-designing and testing a new model of system navigation within a geographic cluster(s);
- HHS and SJHH will partner with Primary Care, patients and families to understand needs related to ambulatory clinics and specialists. This will include understanding wait times, developing priority rating where this does not exist to support timely access, identifying needs of changing demographics and gaps in current system (e.g. frailty clinic with focus on quality of life/advance care planning, and enhancing access to virtual care);
- Asset map navigation activities across all sectors including French Language services navigation;
- Complete a gap analysis for those providing navigation services with Year 1 priority populations;
- Understand the utilization of volunteer work and peer support as a way to expand low-barrier options to support navigation.

As with care coordination, system navigation is present in our community but the needs of Year 1 and attributed populations are not clearly understood. We know that system navigation roles are not consistently available to patients and there is variability in the role. A first step in understanding effective system navigation will be to map the current capacity amongst hospital, community providers, primary care and municipalities (see Question 6.1.). Once current capacity is understood, mapping out resources and completing a gap analysis will be used to understand where resources can be shared, utilized differently, and where gaps remain. Understanding access gaps to ambulatory
and specialist care, and how system navigation can assist with this will also be explored Year 1 led by our two acute hospitals. As an HHT, we would be interested in testing innovative patient navigation models and will be looking for Ministry support as further described in Question 6.5 – 6.6.

Measuring success
We will develop measures and indicators to measure success of system navigation in Year 1. Successful system navigation will be demonstrated when:
- We achieve improvement in patient and population health outcomes;
- Patients will feel supported in the journey through social and health care services;
- Options for accessing care are understood by patients, families, caregivers, and providers;
- There is equitable access for health services;
- System navigation will be developed at both and individual and population level for identified Year 1 cohorts; and
- The Patient Declaration of Values has been implemented.

3.3.3. How will you improve care transitions?
Patients should experience seamless transitions as they move from one care setting or provider to another. Beyond care coordination and system navigation, please identify any specific actions your team plans to take to improve care transitions and continuity of care for your Year 1 population. Describe what initiatives or activities the members of your team currently have in place to improve transitions and explain whether and how you will build off this work in your first year of implementation.

Describe how you will determine whether you have improved transitions of care.

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Our Year 1 target populations are using a disproportionally high share of health care resources as evidenced through health and social service utilization data (see Questions 1.2, 1.3.). These populations can often experience sub-optimal outcomes and poor experience due to fragmented transitions between care settings and limited focus on the social determinants of health. Much of the work identified in our Year 1 redesign aims to improve the transitions of patients by incorporating integrated care delivery models.

There are many initiatives currently underway in our community related to improving transitions with successful outcomes. These strategies encompass all sectors and members of our HHT. These initiatives include:
- Transitional Care Bed Program: an alternative, community-based option for patients who are discharged from acute care but not ready to return home.
- Central Intake for Specialized Geriatric Services: streamlined referrals and processes for those needing specialized geriatric services provided in collaboration with the Regional Geriatric Program as of August 2019.
- Home First Philosophy: promotes standard 48 hour discussions on plan of care and
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- Early referral to HNHB LHIN Home & Community before patients are designated ALC.
- Community Paramedicine Program: identifies patients who frequently use 911 services. Trained paramedics perform health and social assessment, and assist with transitioning patients to the most appropriate care providers.
- ALC to Home Quality Improvement Plan (QIP): aims to remove discharge barriers and pre-plan HNHB LHIN Home & Community supports for patients to avoid designation of ALC through early engagement with patient and family.
- Vanier Towers Project: coordinated teams of providers in a set geographical location
- Standardized reviews of all patients with ALC designsations and revision of plans as patients’ needs indicate.
- Identifying patients at high risk for frailty using the Assessment and Urgency Algorithm (AUA) to ensure supportive plans are developed thereby avoiding adverse outcomes.
- Collaboration with Able Living to transition patients with respiratory needs, beginning with patients who require chronic ventilation (inclusive of training, education, co-managing patients through the transition).
- Expanded ED Admission Avoidance Program, a proven model for early identification of patients requiring immediate home support before they are admitted to the hospital and become at risk for being ALC.
- Nurse Led Outreach Teams: team of nurse practitioners dedicated to supporting long-term care home patients to receive required care in their home thereby avoiding hospital visits and admissions.
- Behavioral Supports Ontario: focuses on enhancing services for older adults with dementia and at risk for or presenting with responsive behaviors, assists with transitioning patients who advanced behaviors into appropriate care settings.

The HHT will continue to learn from these initiatives in Year 1, and develop a strategy to spread and scale the most effective initiatives to Maturity. The HHT team will draw on the robust organizational capacity of the partnerships developed. The HHT participating organizations have significant health leadership experience related to the implementation, management and oversight of health and social services programs and will continue to be dedicated to finding new and improved ways to create a system of seamless transitions between care settings. In addition to the strategies already in place in Hamilton listed above, the HHT has committed to the following new initiatives for our Year 1 populations:
- Initiate focused transition work in geographical cluster(s) that includes new model of care coordination and system navigation.
- Creation of a bed management system so all stakeholders know in real time what residential/supported housing beds are available in the community.
- Develop a 24/7 wraparound transition model from hospital to community leveraging one point of contact and virtual visits complex patients at-risk for adverse events.
- Identify opportunities related to transitions into, within, and from hospitals including ambulatory and specialist care to support seamless continuum of care and providing the right care in the right place at the right time.
- Creation of inpatient to inpatient protocol between HHS’s McMaster Children’s Hospital (children’s site) and SJHH (adult site).
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- Support the development of a region-wide transitional age youth protocol.

Measuring Success
We will develop measures and indicators to measure success of care transitions in Year 1. Successful transitions in care will be demonstrated by:
- Improvement in patient and population health outcomes;
- Improvement in patient and provider experience;
- Integration of both health and social services;
- Fewer gaps in the care continuum;
- Providers communicating care plans across multiple settings;
- No gaps in care are seen between children and adult health and social systems; and
- Adequate and appropriate housing options.

3.4. How will your team provide virtual care?
The provision of one or more virtual care services to patients is a key Year 1 service deliverable for Ontario Health Teams. Virtual care enables patients to have more choice in how they interact with the health care system, providing alternatives to face to face interactions. This includes virtual visits that allow patients to interact with their healthcare providers using telephone, video or electronic messaging; websites and apps that provide patients with easy access to their health records; innovative programs and apps that help patients manage their condition from their homes; and tools that allow patients to book appointments online and connect with the care they need. Ontario’s approach to virtual care makes care more convenient for patients, provides patients with choices about how they receive and manage care, and ensures that virtual care is only used when clinically appropriate and preferred by the patient. At maturity, teams are expected to provide patients with a range of digital choices.

Please refer to Appendix B – Digital Health to provide your proposed plan for offering virtual care options to your patients.

3.5. How will you support patients (and caregivers) to be active participants in managing their own health and health care?

3.5.1. How will you improve patient self-management and health literacy?
Evidence from high-performing integrated systems shows that new approaches to care need to be flexible and adaptive to individual patient goals. Describe your proposed plan for helping patients manage their own health. Describe which of your Year 1 patients (e.g., which health conditions) will receive self-management and/or health literacy supports, and the nature of those supports. Include a description of your team’s existing self-management and health literacy tools, processes and programs, and describe how you will build off this existing infrastructure to enhance these functions for your Year 1 population.

Max word count: 500
As the HHT looks to improve integrated care for all three of our target populations, patient self-management and health literacy will be an essential component to improve the health of our community. When patients feel more supported by their care team, we know positive outcomes in disease and symptom management will follow. A focus for Year 1 will be to improve patient self-management and health literacy for all 3 populations. Targeted initiatives will be focused on patient goal-setting, improving access to health information, streamlining education for patients related to chronic disease management using evidence based tools, and identifying opportunities to promote health literacy.

Members of the HHT have various existing tools and processes in place that the team plans to build off for Year 1. Some of the HHT’s current self-management and health literacy supports include:

- The HNHB LHIN Discharge Transitions Bundle which utilizes teach-back to educate and assess health literacy for patients with COPD and Congestive Heart Failure. Action plans are also an important component of the Bundle written to support the self-management skills.
- Remote Patient Monitoring: patients monitor and record their own vital signs to self-manage chronic diseases such as COPD, CHF, and diabetes (see Appendix B, Virtual Care)
- Community Paramedicine Clinics: education, assessments, and referrals completed in “drop-in” clinics in supportive housing locations across the city
- YourSpace: supports created for youth and families waiting for child and youth mental health services that include live online education sessions, archived videos, and print resources (see Appendix B, Virtual Care).
- Electronic solutions such as MyDovetale and MyChart that allow patients to access their own medical chart (see Appendix B, Digital Access to Health Information)
- Education sessions and programming through the Alzheimer Society for patients with dementia and their caregivers that help build capacity managing the disease
- Health professionals and hospital educator roles such Diabetes Nurse Educators that work with patients and families to develop self-management skills and bridge identified gaps.
- OTN’s Big White Wall digital self-care tool providing online mental health and wellbeing services.
- Our member organizations also have experience with patient self-management tools such as McMaster University’s TAPESTRY program and Optimal Aging Portal for Health Literacy.

The HHT will work with Year 1 patients to determine which approaches will maximize their health literacy and self-management skills. Given the strength of the Digital Health component of our Full Application, existing tools and processes will be easily scaled to the cohort.

3.5.2. How will you support caregivers?
Describe whether your team plans to support caregivers and if so how. In your response, include any known information about caregiver distress within your
community or attributed population, and describe how your plan would address this issue.

**Max word count: 500**

Patients and caregivers have been front and center in the HHT planning process since inception. Caregivers (formal and informal) are an integral part of the support system for those in our community.

We know many caregivers feel overwhelmed. We have heard this in our planning sessions from patients and families and we have heard this from the organizations providing health and social services. Caregiver distress in our community has also been evidenced by:
- 50% of individuals who had a completed RAI assessment in 2018-19, indicated "yes" to any of three caregiver distress questions
- 49% of caregivers in the Hospital 2 Home program have indicated feeling overwhelmed by a person’s illness or condition
- 45% of care partners to someone living with dementia report distress – nearly double the rate of caregivers as a whole

We know this is only a fraction of caregivers, as it includes only those experiences captured in formal mechanisms to date.

As our attributed population continues to age, we expect caregiver burden to increase. Our priority populations for Year 1 are especially at risk for caregiver distress and burden. For example, for older adults living with dementia, it is estimated that caregivers can spend anywhere from seven to 15 hours per day providing assistance with daily living activities (13).

Caregivers need strategies to thrive and be resilient. There are some current approaches to supporting caregivers among our HHT member organizations. The Hospital 2 Home program surveys patients, families, and caregivers to determine program priorities and improvement opportunities. The ICC program provides one contact number which allows caregivers one touchpoint when they are concerned. The Alzheimer Society currently offers programming for caregivers to handle responsive behaviors and learn skills to promote their own self-care. Caregivers in Hamilton currently have access to 12 short stay respite beds located in long-term care homes and 6 overnight community respite beds.

The objective of integrated care approaches, including care coordination, system navigation, and attention to seamless transitions for our Year 1 populations is to increase support and decrease the burden experienced by caregivers.

Our Year 1 work plan includes the following initiatives that will support caregivers:
- Continue to spread and scale models of care that support caregivers such as Hospital 2 Home and ICC;
- Co-designing models with providers alongside patients and caregivers to ensure
caregiver priorities are at the centre of planning and implementation;
- Embed evidence-based caregiver tools from the Change Foundation;
- Explore the need for innovative respite models and day programs that provide flexibility and choice;
- Strengthen care coordination and system navigation so caregivers and their families feel more support, closer to home, and have consistent touchpoints;
- Implement digital resources for patient and caregivers to access their own information.
- Expand opportunities for families with children with mental health issues to take part in Emotion Focused Family Therapy program
- Establishing low-barrier, walk-in, mental health counseling centres for children, youth and the families.
- Re-alignment of public health and school-related family supports for children and youth experiencing difficulties.

3.5.3. How will you provide patients with digital access to their own health information?
Providing and expanding patients’ digital access to health information is an important part of the Ontario Health Team model in Year 1 through to maturity.

Please refer to Appendix B – Digital Health to provide your proposed plan for providing patients with digital access to their health information.

3.6. How will you identify and follow your patients throughout their care journey?
The ability to identify, track, and develop sustained care relationships with patients is important for strengthening relationships and trust between patients and providers, implementing targeted care interventions, and supporting clinical follow up and patient outcome measurement.

Describe the mechanisms, processes, and/or tools that your team proposes to use to collectively identify, track, and follow up with Year 1 patients.

Max word count: 500
In Year 1, we plan to build on existing methods of identifying and following our patients throughout their care journey. As described previously (Section 2, 5), our team has experience tracking patients through integrated care pathways through various methods.

To help support identification and follow-up of patients throughout their care journey, we will expand our current digital health assets across members of our team in Year 1. Examples of our strongest assets for identifying and following patients through the system are detailed below. These methods of sharing information will be scalable to Maturity across our attributed population and new members.
ClinicalConnect: ClinicalConnect is a secure, web-based portal that provides authorized providers with real-time 24-7 access to their patients’ electronic medical information including historical data from acute care settings, oncology, and home and community care records. ClinicalConnect also aggregates data from five provincial repositories and launches from various primary care point of service systems enabling providers to share data amongst themselves to optimize healthcare delivery, patient care, and safety. Nine of our HHT member organizations are already using ClinicalConnect and several others are in the process of gaining access. In Year 1 of HHT, we plan to increase uptake of ClinicalConnect to additional care sectors to build a more fulsome repository of information for providers accessing and sharing patient data (see Appendix B2.3).

Client Health and Related Information System (CHRIS): We will continue to use the CHRIS Home and Community Care platform to support the delivery of home and community care services, as well as coordinate other health services including long-term care placements and referral to community support services within our HHT.

eReferrals and eConsults: In Year 1, our HHT will work to identify barriers and promote uptake of eReferral and eConsults among member organizations to enhance how providers communicate to support transitions in care. Both platforms have improved patient experiences including reducing wait times and inappropriate referrals.

Integrated Decision Support Business Intelligence Solution (IDS): IDS is a multi-organization patient level data repository and business intelligence tool that offers the ability to track an individual through the continuum of care. Through IDS, 10 of our member organizations can access information on individuals across acute, primary, and community care sectors (see Appendix B2.4). Additionally, in Year 1 we will expand IDS to collect data from additional care areas involved in an individual’s care pathway to help implementation and evaluation of integrated care models and patient outcome measurement.

Non-Digital Transmission: Through our HHT planning workshops, it was raised that some providers (particularly smaller practices) use non-digital methods such as fax to transmit patient information from other providers. In Year 1, we plan to identify all non-digital methods of transmission currently in use and work to promote digital opportunities where available (see Appendix B).

3.7. How will you address diverse population health needs?
Ontario Health Teams are intended to redesign care in ways that best meet the needs of the diverse populations they serve, which includes creating opportunities to improve care for Indigenous populations, Francophones, and other population groups in Ontario which may have distinct health service needs. In particular, Ontario Health Teams must demonstrate that they respect the role of Indigenous peoples and Francophones in the planning, design, delivery and evaluation of services for these communities.

Considering your response to question 1.3 and according to the health and health care
needs of your attributed population, please describe below how you will equitably address and improve population health for Indigenous populations, Francophones, and other population groups who may experience differential health outcomes due to socio-demographic factors.

3.7.1. How will you work with Indigenous populations?
Describe whether the members of your team currently engage Indigenous peoples or address issues specific to Indigenous patients in service planning, design, delivery or evaluation. Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Indigenous health or health care needs in Year 1 or longer-term.

How will members of your team provide culturally safe care? Does your team include Indigenous-led organizations as members or collaborators? Why or why not?

Max word count: 500
Hamilton is adjacent to Canada’s largest First Nations Reserve, and has a substantial urban Indigenous population. Our attributed population includes 4,628 people from the Mississaugas of the Credit Reserve and over 2,000 people from Six Nations of the Grand River. Question 1.3 indicates that Indigenous people are likely to be over-represented in the HHT’s Year 1 populations and expanding our capacity to include this population is a necessity.

De dwa da dehs nye’s Aboriginal Health Centre provides a wide range of health services to Indigenous people in the Hamilton area, including the two Reserves. Their holistic approach to services includes primary care, traditional healing, access to Elders, foot and dental care, mental health counselling and consultations, and community development. Their involvement in the planning and implementation of HHT strategies as a collaborator will be invaluable.

Additionally, as part of the Geographic Cluster initiative, De dwa da dehs nye’s Aboriginal Health Centre is leading a redevelopment project of the former St. Helen’s elementary school in northeast Hamilton. The proposed project will relocate and expand the health centre’s programs, add Indigenous child care and housing programs, while partnering with McMaster’s Department of Family Medicine to provide primary care to the surrounding neighbourhoods. The City of Hamilton and neighbourhood groups will also deliver income, housing, child care, and community development support in a truly innovative partnership based on the principles of reconciliation.

Many HHT member organizations have initiatives to engage Indigenous peoples and are committed to implementing the Recommendations from the Truth and Reconciliation Commission (TRC). We will build on these strategies and work with De dwa da dehs nye’s Aboriginal Health Centre to provide culturally safe care Year 1.
through to Maturity. Some examples of these initiatives:
- SJHH engages with the Six Nations Health Team and patients in Ohsweken. Located at White Pines Wellness Centre, the SJHH Renal Program provides Nephrology Clinics, in-centre and home dialysis care and regularly meets with the Reserve Health Team leadership to improve patient experience and increase access to care.
- HHS offers Indigenous Patient Navigator services to support Indigenous patients and their families through their healthcare journey with cancer. In collaboration with De dwa da dehs nye>s Aboriginal Health Centre, Indigenous Patient Navigators support hospital patients across a range of cultural health issues including communications with health care teams and connecting patients with traditional healers.
- For 20 years, SE Health has invested in a First Nations, Inuit, and Metis (FNIM) Program, which reaches 70% of FNIM communities across Canada. The Program enhances the capacity of FNIM communities to understand and solve complex health care issues, improve access, and address barriers to care. Content is developed in full partnership with FNIM communities, and is focused on training, action-based research, and co-designing solutions.
- The City of Hamilton recently completed an Urban Indigenous Strategy that promotes a better understanding about Indigenous histories, cultures, experiences and contributions, while carrying out the TRC Recommendations at the local level.

3.7.2. How will you work with Francophone populations?
Does your team service a designated area or are any of your team members designated or identified under the French Language Services Act?

Describe whether the members of your team currently engage Francophone populations or address issues specific to your Francophone patients in service planning, design, delivery or evaluation. (This includes working towards implementing the principle of Active Offer). Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Francophone health or health care needs in Year 1 or longer-term.

**Max word count: 500**
Hamilton is a designated community under the French Language Services (FLS) Act, with over 6,700 Francophones, and over 30,000 people who speak both English and French. Five of our HHT member organizations are identified as French language providers: HHS, SJHH, CMHA-Hamilton, the Alzheimer Society, and the City of Hamilton’s social services departments.

The HHT is also fortunate to have the Centre de santé communautaire Hamilton/Niagara who is a designated French Language provider under the FLS Act, as a collaborator, with the intention of joining as a member organization. The Centre de santé communautaire Hamilton/Niagara provides a wide range of services.
including primary care, allied health, immigration support, and service navigation. Guidance and leadership by the Centre will be invaluable for guiding integrated models of care to address Francophone health and well-being. In addition, the HHT will seek the guidance of other stakeholders, such as community agencies, the French Language Health Planning Entité2, and patient/client representatives.

There is a significant challenge in Hamilton regarding FLS. There is a paucity of data about Francophones who are accessing services, as records of these visits are rarely tracked, aggregated, or mapped. The linguistic needs of patients are not always identified at intake. Similarly, there is a relative scarcity of third party French-language home care providers in Hamilton.

There are also efforts currently underway by HHT member organizations to engage Francophones that we will continue to build on, including:
- SJHH has three programs that are offered in French as well as signage and literature (brochures) in French (COAST, East Region Mental Health and Womankind). SJHH also has a Language Access Program which provides in-person or telephone interpretation in over 200 languages (including French).
- HHS provides translation services to ensure Francophone patients and families can fully participate in health assessment and care planning. The Ron Joyce Children’s Health Centre has readily available French speaking staff working closely with children and families accessing care. An action plan has been developed to explore further opportunities to ensure Francophone patients and families have timely access to care provided in French language.
- CMHA Hamilton is an identified FLS organization. Currently they have two bilingual staff providing intensive case management services and housing support to Francophone individuals. All agency client service forms are available in the French language, and we have bi-lingual literature and signage.
- The Alzheimer Society is an identified FLS agency who actively recruits staff who are able to provide services in French.

In Year 1, the HHT is committed to quantifying and better understanding the needs of Francophones in our community. By collaborating with the Centre de santé communautaire Hamilton/Niagara and the French Language Health Planning Entité2, the HHT is committed to mapping existing services through the continuum of care for our Year 1 target populations. The HHT will ensure a FLS lens is integrated in all working groups.

3.7.3. Are there any other population groups you intend to work with or support?
Describe whether the members of your team currently engage in any activities that seek to include or address health or health care issues specific to any other specific population sub-groups (e.g., marginalized or vulnerable populations) who may have unique health status/needs due to socio-demographic factors. Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend
to expand or modify these activities in Year 1 or longer-term.

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As set out in Question 1.3, people who live in high poverty or materially-deprived areas will be a major focus of Year 1 initiatives within our HHT. Hamilton has one of the highest concentrations of urban poverty, which results in geographic patterns with elevated rates of premature death, mental health issues leading to ED visits, social isolation, disability, suicide attempts, and drug use.

In addition to these patterns, we also know that equity-seeking groups can be at higher risk of health issues. In Year 1, we will undertake a thorough Equity, Diversity, and Inclusion audit, which will help us develop tailored strategies to reach particular disadvantaged and marginalized groups.

The Hamilton Spectator’s original Code Red series and ten-year update “Code Red 10 years later”, brought neighbourhood health inequities into a stark and disturbing focus. The roots of the Hamilton Community Health Working Group began in an effort to address these challenges.

Additionally, many of our HHT member organizations are very active addressing material deprivation and the social determinants of health through the following initiatives:
- The HHS Hospital 2 Home program incorporates strategies to optimize health outcomes and improve patient experience for those living in materially deprived neighbourhoods and who utilize a high share of health care services.
- Thrive Group provides services to individuals often living below the poverty line. Their supportive housing, assisted living HUBS, and low acuity, in-home care services are designed to meet individual’s unique health care needs. Thrive Group has constructed low income seniors housing buildings which provide health and social supports.
- Indwell and Good Shepherd Community Housing provide over 800 units of supportive housing for older adults with multiple chronic conditions as well as individuals with mental health and addiction issues.
- Wesley Urban Ministries has a long history of working with disadvantaged and marginalized groups around homelessness and housing, mental health and addiction, and other forms of material deprivation.
- The City of Hamilton offers income support programs, a child care subsidy program, subsidized housing, and a range of other emergency supports to people facing material deprivation and who are living in neighbourhoods where material deprivation is present.
- Wayside House provides integrated residential addiction treatment and supportive housing for men and transitional aged male youth. Addressing the full range of social determinants of health including housing, employment, health and supports for those with concurrent disorders.
- CMHA-Hamilton’s Primary Health Care Clinic supports Hamiltonians who are experiencing homelessness and are without a primary care provider. Two CMHA RNs with expertise in concurrent disorders provide coordinated care for these
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individuals within CMHA’s clinic team of physicians, 2 psychiatrists and a RAAM Nurse Practitioner. For individuals involved in the criminal justice system, CMHA provides housing support, care coordination and a range of Court Support services to reduce recidivism.

In Year 1, we intend to draw on the expertise of all our HHT member organizations in order to effectively intervene and improve outcomes for populations living in materially deprived areas.

3.8. How will you partner, engage, consult or otherwise involve patients, families, and caregivers in care redesign?
Describe the approaches and activities that your team plans to undertake to involve patients, families, and caregivers in your Year 1 care redesign efforts. Describe how you will determine whether these activities have been successful.

Max word count: 1000
Our HHT member organizations are passionate about improving care for patients, families, and caregivers in our community. As a team, we have partnered with patients, families, and caregivers to redesign care for Year 1, in alignment with the Patient Declaration of Values. By co-designing our HHT model with our patient, family and caregivers front and centre, we are building an inclusive, transparent, and connected health care system that improves patient, family, and caregiver experiences. As our patients, family and caregivers have been full participants in this process (rather than advisors), they are referred to as ‘patient participants’ throughout our Full Application.

Grounded in our core principle of patient centricity, two patient participants are co-chairing the HHT steering committee. Our current co-chairs are patient participants with lived experience who also have experience serving on our member organization’s PFACs. Our co-chairs have helped ensure that patients, families, and caregivers are always at the forefront of our work. They have been an instrumental part of both our governance and leadership structures, but also through co-design of our integrated care models for Year 1. As described in Question 4.2., we will continue to have patient co-chairs embedded as participants throughout our governance and leadership structures to provide input, advice, and potentially leadership, as we make decisions on development and implementation of various aspects of our HHT in Year 1.

Additionally, we have had 15 patient, family, and caregiver participants who have contributed to our redesign efforts through participation in our HHT workshop planning sessions. Our patient participants are also members of our various working groups - each working group’s membership had a minimum of one patient participant. Our
patient participants were invaluable in providing their perspective, input, and advice as we redesigned care together for our Year 1 populations. Our HHT Project Management Team and patient co-chairs worked with our patient participants throughout the planning process to ensure they felt like they were being heard, and answered any questions or concerns they had throughout. All participants of our workshops (patients and providers) were briefed on our patient engagement framework and Patient Declaration of Values to ensure meaningful patient engagement as all worked together to co-design Year 1 integrated models of care. As we move forward through development and implementation, patient, family, and caregiver participants will continue to be members of each of our Working Groups in Year 1 to ensure a patient-centric approach to care.

To ensure our patient, family, and caregiver engagement in co-design is successful, we will evaluate our engagement strategies and experience outcomes on an ongoing basis. Beginning with our HHT planning workshops held in August and September 2019, we conducted an evaluation of both our patient participants as well as the provider leads of our Working Groups to identify aspects of the engagement process that worked well and which needed to be improved. We did this through an anonymous survey distributed to patient participants and Working Group leads following the workshops. This feedback will be used to help improve future engagement activities for our HHT. We will also continue to evaluate patient participant experiences in future HHT activities through ongoing patient participant meetings and surveys. As described in Appendix B, we will also continue to monitor patient experience outcomes to ensure our integrated models of care are improving the patient, family, and caregiver experience in Year 1 through to Maturity.
### 4. How will your team work together?

#### 4.1. Does your team share common goals, values, and practices?

The development of a strategic plan or strategic direction that is consistent with the vision and goals of the Ontario Health Team model (including the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management) is a Year 1 expectation for Ontario Health Team Candidates. Describe the degree to which the members of your team already share common organizational goals, values, or operating practices and how these align with the Ontario Health Team model. Where there are differences, please describe whether they would need to be addressed as part of your partnership going forward.

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<td>Our member organizations share common goals, values, and operating practices. As an HHT, we have committed to working cooperatively, collaboratively, thoughtfully, and diligently to create a more integrated and highly-patient centred health system for our community by building on earlier successes of our members. As part of the Self-Assessment process, we developed a Project Charter, which all of our members formally endorsed and signed. The Charter outlined the following:</td>
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We envision 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, including:

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

System innovation and integration that delivers:
- The right care at the right time in the right place;
- A focus on population health;
- On-demand technology and digital solutions;
- Integrated data to better understand health and how it’s determinants impact outcomes;
- Improved care coordination across a full spectrum of services;
- The most effective use and uptake of system resources;
- Maximized capacity of the system;
- Smooth transitions and warm handoffs; and
- Reduced disparities in outcomes for different populations.

Effective partnerships that:
- Are aligned on one core philosophy;
- Have a holistic view of the population and focus on addressing the key issues they face;
• Build collaborative relationships between health and social care;
• Address social determinants of health for all;
• Are able to demonstrate benefits; and
• Are inclusive to patients, families, caregivers, care providers.

And organizational design that:
• Creates shared space for partners to work together;
• Optimizes every dollar spent to drive outcomes; and
• Enables joint accountability for moving the system forward.

Finally, the Charter outlined the principles that shape the design of the HHT:

• Patient-centric care: Co-design system with patients, families and caregivers; ensure system equity and inclusiveness of marginalized communities; inform and empower patients; alignment with the Patient Declaration of Values for Ontario.
• Shaped by the community: Act as an engine to change Hamilton; balance the needs of patient care and population health; engage the community in the right way
• Embedded continuous improvement and innovation: Embed rapid and continuous learning at all levels, make evidence based decisions; design for flexibility to adjust for learnings; design for sustainability and scalability; enable and operationalize accountability for the system by every partner.
• Value Driven: Leverage current assets, resources and existing strengths to maximize value creation for our community and the health system.
• We will be respectful of our work together recognizing that we may not always agree and will need to have some difficult conversations.
• We will be transparent in sharing information and data.
• We will be accountable for our decisions and actions.

We believe we have been successful in developing our shared vision and goals across our HHT, as many member organizations already share similar visions and goals as individual organizations. This is true particularly around improving the wellbeing of our patients and community, providing integrated and innovative services in a respectful way, transparency, and collaboration.

4.2. What are the proposed governance and leadership structures for your team?
Ontario Health Teams are free to determine the governance structure(s) that work best for them, their patients, and their communities. Regardless of governance design, at maturity, each Ontario Health Team will operate under a single accountability framework.

Please describe below the governance and operational leadership structures for your team in Year 1 and, if known, longer-term. In your response, please consider the following:
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- **How will your team be governed or make shared decisions?** Please describe the planned Year 1 governance structure(s) for your proposed Ontario Health Team and whether these structure(s) are transitional. If your team hasn’t decided on a governance structure(s) yet, please describe the how you plan to formalize the working relationships among members of the team, including but not limited to shared decision making, conflict resolution, performance management, information sharing, and resource allocation. To what extent will your governance arrangements or working relationships accommodate new team members?

- **How will your team be managed?** Please describe the planned operational leadership and management structure for your proposed Ontario Health Team. Include a description of roles and responsibilities, reporting relationships, and FTEs where applicable. If your team hasn’t decided on an operational leadership and management structure, please describe your plan for putting structures in place, including timelines.

- **What is your plan for incorporating patients, families and caregivers in the proposed leadership and/or governance structure(s)?**

- **What is your plan for engaging physicians and clinicians/clinical leads across your team’s membership and for ensuring physician/provider leadership as part of the proposed leadership and/or governance structure(s)?** For non-salaried physicians and clinicians, how do you plan to facilitate their meaningful participation? What approaches will your team use to engage community-based physicians and hospital-based physicians?

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**Overview:**

In Year 1, the HHT will build on the success of the governance and leadership model that brought together a diverse set of member organizations, health system leaders, front-line physicians and clinicians, and patient participants from the core sectors of an OHT model. Within the current structure, we successfully developed and articulated both a Vision statement and goals for our HHT, successfully submitted a Self-Assessment, and now this application to the Ministry.

The HHT recognizes the significance and challenges in establishing governance and financial models that will meet the needs of our patients, caregivers and health service today, and advance towards a single accountability framework in the future. The HHT is pleased to be in a position to leverage our existing governance structures to complete this work.

There are four distinct groups:

1) The Executive Committee made up of a smaller number of Partnership Council members – who will ensure that timely decisions can be made on issues of resourcing the work of the HHT, responding to member issues, monitoring performance and communicating the work of the HHT;

2) The Partnership Council which is the full group of member organizations that will drive the overall Vision and direction of the HHT, approve new members of the HHT, act as ambassadors for the HHT, and continue to encourage collaboration and outreach to
all those providing health and community services in our community;
3) The Oversight and Coordination Secretariat that will provide staffing resources and
oversee the redesign of health service delivery by Working Groups in Year 1;
4) The Working Groups that are responsible for developing work plans that will see the
HHT deliver on its Year 1 goals, including development of redesigned care for older
adults with multiple chronic conditions and individuals with mental health and addictions
conditions. The Working Groups will also develop the necessary protocols, contracts
and agreements necessary for the work to be successful, and for approval by the
Executive Committee.

All levels of the HHT governance structure will continue to include 1) health system
leaders, 2) physicians and clinician leaders; and 3) patient participants who will provide
input, advice, and potentially leadership as each team makes decisions. As our team
evolves, our governance and leadership structures will evolve to address the needs of
our HHT, member organizations, and community.

The HHT will also be supported by staff – both full and part-time – who will be
responsible for the day-to-day activities that will ensure we can fully implement our work
plans.

Some priorities for Year 1 that we will undertake:
• The formalizing of the Partnership Council relationships through the execution of a
“Master Agreement” that clearly lays out roles, responsibilities, expectations, and overall
deriverables for HHT member organizations
• Establish processes for member and chair selection at each level of governance;
• Development of Conflict of Interest and Procurement policies that do not exist today;
and
• The added responsibility of developing protocols, agreements or contracts at the
Working Group level to ensure clear accountability and funding relationships to support
the implementation of work plans.

(1) Executive Committee:

Composition:
Seven (7) senior leaders selected from the Partnership Council to serve as members of
the Executive Committee and two patient participants. Members must be the senior
decision makers of the organizations or the part of the organization represented at the
Partnership Council (Department/Divisions/local branches etc.). Membership will reflect
the core sectors of an OHT. The Chair of the Executive Committee will be selected from
the members. Patient participants will be selected from Patient and Family Advisory
Councils (PFAC) or volunteer base of HHT member organizations. Patient participants
will have received appropriate patient advisory training through their respective
organization and/or the Ministry prior to being selected to serve on the Committee.

Role:
• Direct overall oversight and implementation of the HHT work plan
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- Identify resources as required to advance the work of the HHT  
- Coordinate processes for hiring staff required to advance the work of the HHT and its various Working Groups  
- Actively participate as members of the Partnership Council  
- Recommend to the Partnership Council the addition/removal of HHT members  
- Approve and monitor actions of the Working Groups  
- Approve HHT communication plan  
- Develop criteria for HHT membership  
- Arbitrating body for any Partnership issues  
- Ensure compliance with applicable laws, agreed upon principles and strategy

Decision-Making:  
- Authority to hire staff as needed to support the work of the HHT and Working Groups  
- Authority to approve the work plans and any agreements that support the implementation at the work group level, including Master Agreement  
- Recommendations to the Partnership Council on issues of membership in the HHT.

Year 1 Transition:  
- Initial membership remains in place, including patient participants  
- Recommend to Partnership Council a process for selection of members by Q3 of Year 1

(2) Partnership Council

Composition:  
The Partnership Council consists of senior leadership from each of the HHT member organizations. When representing an organization, members must be the senior decision makers of their organization or the part of the organization represented at the Partnership Council (e.g. Department/Divisions/local branches etc.). The Chair of the Partnership Council will be selected from the members. Members of the Partnership Council will be signatories to a Master Agreement outlining the roles, responsibilities and expectations of HHT member organizations. Two patient participants will also serve as members of the Partnership Council and will be selected from PFACs or volunteer base already established at their respective member organizations.

Role:  
- Ensure positive and collaborative working relationships among all member organizations in the HHT in accordance with the Project Charter and Vision  
- Enter into a Master Agreement that clearly lays out roles, responsibilities, expectations, and overall deliverables for all member organizations, including how HHT member organizations will engage their governing bodies  
- Review and approve membership in the HHT  
- Act as ambassadors for the Vision of the HHT within the broader community  
- Promote collaboration with providers of service in support of the outcomes desired by the HHT  
- Review the performance of the HHT
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- Review and provide input on Working Groups' work plans for Year 1 and maturity;
- Identify staff and resources to support Working Groups and implementation of work plans.

**Decision-Making:**
- Approve any changes to the Vision and Charter of the HHT
- Approve members of the HHT
- Select the members for the Executive Committee

**Year 1 Transition:**
- Develop criteria for membership of HHT, recruit to fill identified gaps
- Develop Conflict of Interest Policy, Procurement Policy and Information Sharing Agreement for members
- Identify patient participants to serve on Partnership Council and Executive Committee

(3) Oversight and Coordination Secretariat (OCS)

**Composition:**
The OCS will consist of senior staff from HHT member organizations and patient participants. Membership will reflect the core sectors of an OHT.

**Role:**
- Provide overall coordination to the development of the HHT health service delivery plans of each Working Group, within the terms of the HHT’s Project Charter
- Provide resources as necessary to develop and implement care/service delivery plans for each Working Group in the interim while HHT hires additional staff
- Develop HHT strategic plan and central brand in Year 1 for review and approval by Partnership Council and Executive Committee
- Provide support to decision-making processes of the Partnership Council, as needed.

**Year 1 Transition:**
- The OCS will provide staffing support from member organizations

(4) Working Group

**Composition:**
A group of HHT member organizations, contracted service providers who currently provide services to focus populations (including front-line staff, clinicians, physicians), and patient participants will come together to form each Working Group.
The seven Working Groups for Year 1 are:
1. Older Adults with MCC
2. Mental Health and Addictions – Adults
3. Mental Health and Addictions – Child and Youth
4. Home and Community Care
5. Digital Health
6. Governance
(7) Primary Care

Role:
The Working Groups will come together to:
• Define and describe each Working Group’s work plan;
• The planned model of care/service delivery (this may be as specific as a care/service plan by day, month, quarter, or year);
• The anticipated outcomes for patients/clients, family, caregivers, providers, and health system;
• The process for monitoring care/service delivery progress and patient, client, family, caregiver, and provider satisfaction
• Identification of additional HHT members, collaborators, providers to ensure full continuum of care and ability to meet demand for services
• Identification of barriers at both a local and provincial level.

Decision-Making:
The Working Groups will come to recommendations with respect to:
• The anticipated resources to be contributed by each member organization in response to the care/service delivery plan for the targeted populations;
• The plan for additional resources to be contributed given the risks associated with the new care/service delivery model (pain share/gain share)
• The process for performance monitoring, reporting and evaluation, and the process for program adjustments as required.

HHT Staff:
• Will support the work of the Executive Committee, Partnership Council, OCS, and Working Groups during the development of the Full Application through to implementation in Year 1 and beyond.
• Project Director reports to the Executive Committee

Year 1 Transition:
• Extend current staffing through to end of January 2020
• Executive Committee to develop job descriptions, funding and recruitment strategies for on-going staffing

4.3. How will you share patient information within your team?
At maturity, Ontario Health Team will have the ability to efficiently and effectively communicate and to digitally and securely share information across the network, including shared patient records among all care providers within the system or network.

4.3.1. What is your plan for sharing information across the members of your team?
Describe how you will share patient information within your team. Identify any known gaps in information flows between member organizations/providers and what actions you plan to take to mitigate those gaps (e.g., are data sharing agreements or a Health
Information Network Provider agreement required?). Identify whether all participating providers and organizations within the team have the legal authority to collect, use and disclose personal health information for the purposes of providing health care and for any administrative or secondary use purposes. Outline the safeguards that will be in place to ensure the protection of personal health information. Append a data flow chart. Identify whether there are any barriers or challenges to your proposed information sharing plan.

_Max word count: 1500_

In Year 1, we plan to build on existing methods of sharing information within our team. As described throughout our application, our team has experience following patients through integrated care pathways and communicating information across organizations through various methods. Currently, our member organizations who provide services to patients and clients are all Health Information Custodians (HIC) with robust privacy and security policies to protect Personal Health Information (PHI).

As detailed in Appendix B-4.3.2, in Year 1 our HHT will expand our current digital health assets across members of our team to help promote digital sharing of information. These methods of sharing information will be scalable to Maturity across our attributed population and new members. We will ensure any new methods of sharing information, or any new members who join our HHT to provide services to our populations will be HICs and Data Sharing Agreements and Health Information Network Provider agreements will be developed where necessary. This work will be completed by our Governance and Digital Health Groups within Year 1 and will be incorporated into the process and requirements for new member organizations and our Master Agreement.

Methods of Information Sharing:
The following assets are currently used to share information among our members. We will continue to work to expand these platforms across providers by addressing barriers within these information sharing methods and promoting provider and patient uptake.

ClinicalConnect: ClinicalConnect is a secure, web-based portal that provides authorized providers with real-time 24-7 access to their patients’ electronic medical information including historical data from acute care settings, oncology, and home and community care records. ClinicalConnect also aggregates data from five provincial repositories and launches from various primary care point of service systems enabling providers to share data amongst themselves to optimize healthcare delivery, patient care, and safety. Nine of our HHT member organizations are already using ClinicalConnect. In Year 1 of HHT, we plan to increase uptake of ClinicalConnect to additional care sectors to build a more fulsome repository of information for member organizations (and new members) who are accessing and sharing patient data (see Appendix B2.3).
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**Client Health and Related Information System (CHRIS):** We will continue to use the CHRIS Home and Community Care platform to support the delivery of home and community care services, as well as coordinate other health services including long-term care placements and referral to community support services within our HHT.

**eReferrals and eConsults:** In Year 1, our HHT will work to identify barriers and promote uptake of eReferral and eConsults among member organizations to enhance how providers communicate to support transitions in care. Both platforms have improved patient experiences including reducing wait times and inappropriate referrals.

**Secure Messaging:** In Year 1, our HHT plans to obtain a secure messaging (SM) platform to be used by all members. The use of SM will provide health care providers with technology that will facilitate communication among members resulting in improvement in the efficient and safe delivery of excellent care. More specifically, an SM solution will:
- Facilitate staff being able to securely communicate to their colleagues electronically
- Automatically direct messaging to clinical resources based on role and their availability in real-time as well as manage escalation of messaging based on predefined service level rules
- Facilitate the day to day management and improvement of services while reducing costs associated with inefficient communication in the clinical environment.

Our HHT will review information requested from SM platform vendors in Year 1 to select a platform that best addresses the needs of our members, including provincial assets available for use by Ontario Health Teams (e.g. ONE Mail).

**Integrated Decision Support Business Intelligence Solution (IDS):** IDS is a multi-organization patient level data repository and business intelligence tool that offers the ability to track an individual through the continuum of care. Through IDS, 10 of our member organizations can access information on individuals across acute, primary, and community care sectors (see Appendix B2.4). Additionally, in Year 1 we will expand IDS to collect data from additional care areas involved in an individual’s care pathway to help implementation and evaluation of integrated care models and patient outcome measurement.

**Non-Digital Transmission:** In addition to digitally sharing information, some providers share information through non-digital transmissions such as fax and phone where necessary. In Year 1, we plan to identify all non-digital methods of transmission currently in use and work to promote digital opportunities where available (see Appendix B).

**Privacy and Security Policies:**
As stated, all of our member organizations who provide services to patient and clients are HICs. As a HIC subject to PHIPA, our member organizations comply with all applicable requirements for the appropriate collection, use, disclosure, storage, retention, auditing, and disposal of personal health information set out in PHIPA. For
example:

Alzheimer Society: Alzheimer Society, as a HIC, utilizes a secure [redacted] database with regular file auditing. Policies and procedures in place to inform and protect PHI. Regular privacy training to all staff.

City of Hamilton: The City of Hamilton as a HIC has policies and procedures in place for protection of PHI, and undertake regular staff training and auditing of access to health records.

CMHA Hamilton: CMHA as a HIC, has a privacy policy in place that is consistent with PHIPA and communicated and agreed to by all employees in the organization. Regular training takes place with the staff and monthly audits are done by the privacy officer to ensure compliance. All clients are notified of their rights and responsibilities regarding consent and sign a declaration of understanding upon commencement of service from the agency. The agency uses Netex to ensure the security of all electronic records based on industry best practices.

Good Shepherd: Written information practices in place that describe the organization’s information management practices. The Chief Privacy Officer designated by Good Shepherd oversees compliance with its privacy policy. Organization is a HIC.

Hamilton FHT: The Hamilton FHT as a HIC has privacy policies and procedures for the organization and requires staff and members to be trained on privacy – at point of hire and regularly thereafter.

HHS: As a HIC, HHS privacy policies are actively enforced, with on-site Privacy Officers at each site with access to lead Privacy Officer at HHS, annual confidentiality contract renewals, and more.

Indwell: As a HIC, Indwell uses a purchased service for collection and storage of PHI with robust third party security. Access to the account is limited to direct service providers or clinical administration staff.

Lynwood Charlton: As a HIC, Lynwood Charlton has numerous policies and procedures in place to manage and protect privacy of PHI, including: Privacy Policy, Security of Computer System and Electronic Devices Policy, Use of Electronic Communications and technological Devices Policy, Communications Policy, Clinical Records Management Policy.

McMaster FHT: As a HIC, McMaster FHT has a full security and access management solution in place to ensure we authorize and audit access to PHI. All data is protected by strong passwords and is fully auditable.

SE Health: As a HIC, SE Health staff safeguards client information according to strict
standards of security and confidentiality. All PHI and Personal Information (PI) is encrypted at rest and in-transit. Their secure Cloud-Based Enterprise Level Platform supports collection and retention of all PHI/PI and meets all of Ontario’s legal and privacy requirements.

SJHH, St. Joseph’s Home Care, St. Joseph’s Villa: As a HIC, SJHH has a dedicated Chief Privacy Officer and a team of Information Security professionals who facilitate the organization’s successful protection of personal health information, and compliance with applicable legislation, eHealth and ISO standards, and best practices.

Thrive Group: As a HIC, Thrive Group has both Privacy and Security policies in place to protect PHI. The policies are aligned with PHIPA and security best practices.

Wesley Urban Ministries: As a HIC, the organization has a very robust privacy policy which covers off the protocols related to all matters of privacy, with a particular emphasis on health information. Wesley also has a privacy officer who regularly reviews protocols and conducts audits.

Wayside House: Wayside house has a privacy officer (the CEO) who monitors privacy. Consent at Wayside House is aligned with PHIPA. Wayside House is a HIC.

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<tr>
<th>4.3.2. How will you digitally enable information sharing across the members of your team?</th>
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<tr>
<td>Please refer to Appendix B – Digital Health to propose your plan for digital enablement of health information sharing.</td>
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5. How will your team learn & improve?

5.1. How will participation on an Ontario Health Team help improve individual member performance or compliance issues, if any?
Identify whether any of your team members have had issues with governance, financial management, compliance with contractual performance obligations, or compliance with applicable legislation or regulation.

Where there are issues, describe whether there is a plan in place to address them. Indicate whether participation on the team will help and why. Indicate whether there will be any formal accountability structures in place between individual team members and the team as a whole for ensuring that individual performance or compliance issues are addressed.

Max word count: 500
Our member organizations have a history of balanced budgets, strong credit ratings, and a track record of strong financial management and performance. Our member organizations have not had any major challenges regarding governance, financial management, compliance with contractual performance obligations, or compliance with applicable legislation or regulation during the development of our HHT submission.

We do, however, anticipate significant benefits to working together in terms of team performance.

As part of the Self-Assessment and described in Section 4, our HHT members signed on to a Charter with a vision and set of Guiding Principles. This agreement between members emphasizes mutual accountability, trust, and transparency in order to deliver the best patient care. As an additional step, Section 4 describes our intention to develop a formal Master Agreement between members of the Partnership Council. This agreement will clarify roles, responsibilities, contributions, and expectations that come with membership in the HHT. Performance and compliance of individual organizations as HHT members will be set out as a key component of the Master Agreement.

5.2. What is your team’s approach to quality and performance improvement and continuous learning?
Ontario Health Teams are expected to pursue shared quality improvement initiatives that help to improve integrated patient care and system performance.

5.2.1. What previous experience does your team have with quality and performance improvement and continuous learning?
Describe what experience each of the members of your team have had with quality and performance improvement, including participating in improvement activities or
collaboratives and how each collects and/or uses data to manage care and to improve performance. Provide examples of recent quality and performance improvement successes related to integrated care (e.g., year over year improvement on target Quality Improvement Plan indicators).

Highlight whether any members of your team have had experience leading successful cross-sectoral or multi-organizational improvement initiatives.

Describe your members’ approaches to continuous learning and improvement at all levels. Indicate whether any members of your team have had experience mentoring or coaching others at the organizational-level for quality or performance improvement or integrated care.

Identify which team members are most and least experienced in quality and performance improvement practices and whether there are any strategies planned to enhance quality focus across all member organizations/providers. Similarly, identify and describe which team members have the most and least data analytic capacity, and whether there are any strategies planned to enhance analytic capacity across all member organizations/providers.

Max word count: 1000

Each of our HHT member organizations have experience with quality and performance improvement initiatives. These initiatives include Quality Improvement Plans (QIP), Accreditation processes, and measuring year-over-year improvement on select indicators. To ensure we learn and improve together as a HHT, we will leverage our individual experience, as well as our experience working together within interagency partnerships. For example, many of our member organizations have worked together to drive performance and improved quality of services delivered in our community:

Initiative: Better Health & Lower Costs for Patients with Complex Needs
Organizations: HHS, SJHH, LHIN HCC, McMaster, Hamilton FHTs, City of Hamilton Public Health and Emergency Medical Services, March of Dimes, Good Shepherd, Catholic Family Services, McNally House Hospice, Canadian Foundation for Healthcare Improvement (CFHI), Institute for Healthcare Improvement (IHI)
Description: A 12 month collaborative to plan and implement comprehensive care designs that serve the needs of our community’s most complex, high-risk, and costly patients – frail seniors. This work was intended to standardize care and reduce variation across teams through developing standardized care pathways for defined patient populations. This was done through reviewing care pathways and associated quality indicators (e.g. ED readmissions) to identify successes and opportunities for improvement, and to redesign and drive better outcomes.
Outcomes: A standardized frailty screening was developed for HHS’s Hospital 2 Home team and in EDs and urgent care centres. New partnerships were developed between organizations who were focused on working together to support frail
patients. Quality improvement education was also provided for community partners and quality improvement opportunities were identified across the system.

Initiative: Integrated Mental Health & Physical Health Care and Supports for Families and Infants
Organizations: City of Hamilton, health and social service partners
Description: The City of Hamilton in partnership with SJHH, HHS, specialist physicians (e.g. OB/GYN, pediatrics), and primary care providers, improved performance and quality by creating more safe transitions during the postnatal period. This was done through standardizing care, defining roles, and developing care pathways.
Outcomes: Through this initiative, this group has produced defined successful care pathways for both general and high risk populations (e.g., Hamilton Pregnancy Care Pathway; Hamilton Youth Pregnancy Care Pathway; Infant Mental Health).

Initiative: Establishing Thrive Group
Organizations: Thrive Group (St. Peter’s Residence at Chedoke, AbleLiving Services, Capability Support Services, Idlewyld Manor)
Description: Thrive Group was established in 2013 to provide a more consolidated and cost effective approach to the provision of infrastructure services for St. Peter’s Residence at Chedoke and AbleLiving Support Services. The governing Boards of each organization understood the need to radically change how back-office supports were structured in order to ensure that, with increasing demands and overstretched budgets, as much of the funding received through their LHINs, project-based funding and donor contributions as possible could be channeled to where it was most needed – quality front-line care for their clients and residents. Since the inception of Thrive Group, the organization has also integrated services with Capability Support Services and Idlewyld Manor and now serves over 3,500 individuals on a daily basis at 17 sites and through in-home services. In addition to working with the internal integrated organizations, Thrive Group also supports over 15 other non-profit organizations with back office supports.
Outcomes: By consolidating each organization’s Human Resources, Information Technology, Finance and Facilities Management functions and recruiting one Chief Executive Officer, overall administrative costs were reduced without sacrificing the strength that an informed and professional back-office infrastructure could offer. By bringing together like-minded organizations, Thrive has developed and delivered quality services that are responsive and innovative, enhanced collaborative approaches to service provision, informed government directives and influenced health care system transformation, and, created efficiencies and reduced duplication. As a result of the integrations, Thrive Group has expanded the back office services model by focusing on quality assurance, enterprise risk management planning and an overall commitment to continuous improvement and service quality excellence.

Initiative: St. Joseph’s Health System (SJHS) Integrated Funding Model Pilot
Organizations: SJHS, HHS, HNHB LHIN, other healthcare organizations across
Ontario Description: In 2015, the Ministry of Health and Long Term Care supported 6 Integrated Funded Model (IFM) pilot projects across Ontario to promote the delivery of integrated, quality, evidence-based care to patients. Through this project, SJHH led the spread and scale of their Integrated Comprehensive Care (ICC) model for COPD and CHF patients to all acute hospitals in the HNHB LHIN and also acted as a coach for each of the 6 IFM pilots in Ontario.

Outcomes: Key successes include reductions in length of stay, readmission and ED visits, while also improving patient and provider experience. Today, with over 17,000 patients served, and over 30,000 Hospital bed days saved, SJHS have established a proven track record of effectively implementing New Models of Care at scale, coaching multiple organizations serving diverse clinical populations, driving value for health care dollars, and improving outcomes for patients. St. Joseph’s is currently the recognized bundle-holder for the HHNB LHIN Integrated Funding model pilot and is supporting 9 acute centres implement integrated care streams for patients with COPD & CHF.

In addition, one of our biggest assets in driving performance and quality improvement is our Integrated Decision Support (IDS) Business Intelligence Solution. This system (as detailed in Appendix B-2.4.), contains patient health information, utilization, and cost data from hospitals, home and community care, and primary care. Using IDS, organizations are able to analyze a variety of indicators to help measure performance and drive quality. In Year 1 of our HHT, we will expand IDS to include emergency medical services, community mental health providers, and additional primary care providers to help strengthen our ability to analyze data and drive performance and quality improvement across our integrated team.

We will also leverage the expert research resources from within our HHT member organizations to inform and advise on current and future practice to improve quality, including McMaster University’s Population Health Research Institute, Centre for Health Economics and Policy Analysis, GERAS Centre for Aging Research, and SE Health Research.

5.2.2. How does your team currently use digital health tools and information to drive quality and performance improvement?

Please refer to Appendix B – Digital Health to provide information on how your team will leverage digital health tools for improvement.

5.3. How does your team use patient input to change practice?

Ontario Health Teams must have a demonstrable track record of meaningful patient, family, and caregiver engagement and partnership activities. Describe the approaches the members of your team currently take to work with patient, family, and caregiver partners and explain how this information gets embedded into strategic, policy, or operational aspects of your care, with examples.
Do any members of your team have experience working with patients to redesign care pathways?

Identify which of your members have patient relations processes in place and provide examples of how feedback obtained from these processes have been used for quality improvement and practice change. Describe whether any members of the team measure patient experience and whether the resulting data is used to improve.

Max word count: 500

Each of our HHT member organizations has experience including feedback from patients, clients, and their families in operational, strategic and policy aspects of service delivery. For example, many of our member organizations have Patient and Family Advisory Committees (PFAC) that have allowed patients, their families and caregivers, to participate in decision-making and program development activities for improvement of clinical services. Below are examples of how our member organizations have embedded patient, client, family input into their organization to create more patient-centred services:

Alzheimer Society: Alzheimer Society obtains feedback from clients in a variety of methods (Client Advisor on Board of Directors, Client satisfaction surveys, client focus groups biannually) that inform their strategic directions and operational planning. Recently, they completed a strategic plan that engaged 80 external partners, funders, community leaders in addition to multiple focus groups with clients and staff.

Good Shepherd: Good Shepherd hires persons with lived experience in their range of services and seeks out client feedback through informal and formal mechanisms to improve services and address services gaps. For example, Good Shepherd recently received feedback from clients who were seeking additional high support housing services but were unable to access them due to lack of availability in the community. In response, Good Shepherd reallocated their resources to one of their existing high-needs buildings to begin to address the need for higher support housing in our community.

St. Joseph’s Health System: SJHS involves patients and families in the care that they provide as well as program development and decision-making including their PFACs, patient satisfaction surveys, and patient relations process. For example, their PFAC recently developed and approved a 2-year Engagement strategy to further the partnership and collaboration between patients and providers. Patients are also incorporated as members throughout SJHS’s committee structure (e.g. Hand Hygiene, Wayfinding, Advanced Care Planning, Falls, ICC, and the Senior Leadership Team) to ensure patient voice and opinion is embedded, and improvements and programs are co-designed.

HHS: HHS has an Office of Patient Experience which manages their patient relations process as well as policies outlining their processes (in alignment with ECFAA) and
patient surveys. Feedback is used to drive improvements at unit level, program levels and for organizational strategic planning. For example, following a patient complaint regarding a pressure ulcer, the involved unit invited the patient in to tell their story and to understand their suggestions for improvement. The unit then embarked on a wound care education program to address the issues raised and to ensure best practices and communication of how the patient could contribute to their care.

As an HHT we have engaged also Patient Participants from our various member organizations’ PFACs to embed the patient voice in our co-design. This includes our patient co-chairs and our 15 Patient Participants who have participated in our planning workshops and are embedded in our governance structure (see Questions 3.8, 4.2). Grounded in our core principle of patient-centricity, Patient Participants will continue to be embedded in our governance structures from Year 1 to Maturity.

5.4. How does your team use community input to change practice?
Describe whether the members of your team formally or informally engage with the broader community (including municipalities), and whether the outcome of engagement activities influence the strategic, policy, or operational aspects of your care.

Max word count: 500

As an HHT we intend to engage the broader community leveraging our current partnerships within the Hamilton Anchor Institution Leadership (HAIL) group as well as individual organization’s experiences with broader community engagement used to improve services. Many of our organizations conduct extensive, formal and informal consultations with residents of our community, community partners, and members of the business community while planning their services.

Hamilton Anchor Institution Leadership (HAIL)

HAIL is Hamilton’s largest public and private sector members including City of Hamilton, SJHH, HHS, LHIN, the local school boards, Hamilton Police Services, McMaster University and Mohawk College, Chamber of Commerce, ArcelorMittal Dofasco and the Hamilton Roundtable for Poverty Reduction. As we work through development and implementation of our HHT, we will leverage the HAIL table to help engage additional community partners (both public and private) for input on how to best serve the needs of our community.

Community Engagement:

Several of our member organizations conduct regular community engagement sessions to help inform design and improvement of current programs including the strategic, policy, and operational aspects. For example, the following member organizations have recently used community input to change practice:

City of Hamilton: In 2014, the City of Hamilton developed a Public Engagement
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Charter to outline the key elements to involving residents in decisions made at the City of Hamilton. This Charter, which is aligned with the City’s Public Engagement Policy is used by all staff to strengthen and improve the City’s ability to consistently undertake appropriate, coordinated, transparent, inclusive, evidence-based public engagement practices. This in turn, enables the public to become more involved in decisions that impact them and their community.

Lynwood Charlton Centre: Lynwood Charlton engages community service providers, including all Child and Youth Mental Health providers and other community partners including Child Welfare and the Education sector representatives in the design of their strategic directions, policy and operational change for both individual organizations as well as the sector as a whole. Lynwood Charlton Hall, in partnership with HHS and Hamilton FHT, also held a community information session on September 4 that provided background and an overview of the HHT approach for Year 1 regarding Child/Youth MHA. Attendees represented 7 community agencies including the Hamilton Regional Indian Centre, child welfare and school representatives, as well as clinicians from McMaster Children’s Hospital.

Wesley Urban Ministries: Community consultation occurs as part of the organization’s strategic planning process. The organization identifies key stakeholders that are interviewed and the information is used to improve services and set out future direction. Wesley has shown particularly strong leadership with regard to consultations around Early Years locations across the city as well as innovative services for people experiencing homelessness.

5.5. What is your team’s capacity to manage cross-provider funding and understand health care spending?
Please describe whether your team has any experience in managing cross-provider funding for integrated care (e.g., bundled care). Have any members of your team ever pooled financial resources to advance integrated care (e.g., jointly resourcing FTEs to support care coordination)? Does your team have any experience tracking patient costs or health care spending across different sectors?

Max word count: 500
Several members of our HHT have experience in managing cross-provider funding and understanding health care spending and utilization to drive performance and improvement.

Managing Cross-Provider Funding and Pooling Resources:
Within Hamilton, we have experience managing cross-provider funding through our participation in Integrated Funding Models and Bundled Care Initiatives. For example, both HHS and SJHH participated in the provincial pilot for Integrated Funding Models (IFM). The findings of this successful program included cost savings for COPD/CHF care at 60 days of over $3,200 per patient.

As described previously, St. Joseph’s Health System also has significant experience in managing cross-provider funding and pooling resources to advance integrated care through their Integrated Comprehensive Care (ICC) model. The ICC model aims to make the patient experience as seamless as possible, while utilizing existing financial, human and technology resources across the health care continuum, to deliver an integrated and comprehensive care experience. The ICC is enabled by an Integrated Funding Model that promotes system redesign. The funding managed by SJHS aligns the right incentives, empowers stakeholders and drives value across the full episode of care. SJHS is currently the recognized bundle-holder for the HHNB LHIN Integrated Funding model pilot and is supporting 9 acute centres implementing integrated care streams for patients with COPD & CHF.

As described previously, the Thrive Group also has experience managing cross-provider funding and pooling resources through the successful establishment of their organization which consolidated the provision of infrastructure services for several community organizations (see Question 5.2.1.).

Healthcare Utilization and Cost Analysis:

Many of our members also have experience analyzing costing and utilization data to determine if interventions are successful and to help improve healthcare quality, performance, and more efficient use of limited resources (see Section 2, 5, Appendix B).
6. Implementation Planning and Risk Analysis

6.1. What is your implementation plan?
How will you operationalize the care redesign priorities you identified in Section 3? Please describe your proposed 30, 60, 90 day and 6 month plans. Identify the milestones you will use to determine whether your implementation is on track.

Max word count: 1500

By formulating our Working Groups early on in the process, the HHT has established the ground work to begin redesign immediately. Each of our Working Groups (Governance, Digital, Home and Community Care, Primary Care, Older Adults, Child and Youth MHA, and Adult MHA) will use the first 30 days to develop their specific plans to guide Year 1 work. The first 90 days will be used to leverage our existing tables of partners, add new members as needed, strengthen governance and leadership structures, expand primary care membership, address performance issues and begin expansion of digital health services, and begin integrating care across sectors with a focus on early identification, geographical clusters and transitions in and out of hospital. The HHT implementation table below focuses on specific milestones that will be achieved in order to redesign care for the patients in our Year 1 populations. Each population’s implementation timeline embeds support from our other Working Groups. Proposed timelines are provided below by Integrated Model of Care and Working Group:

HOSPITAL TRANSITIONS

30 - 60 - 90 Days:
- Develop an approach to standardize the method of patient identification and assessment of ‘high users’ within our Year 1 populations
- Review new and current pathways to be expanded to ensure inclusion of health, social, community, and specialist care within integrated care model.
- Review and scope work plan for HHT transition model for those admitted with MHA concerns, Older Adults with MCC
- Review current bed management models for residential and supportive housing options, map future state and accountabilities for city-wide bed management model
- Leverage work of the MHA Child and Youth Working Group to begin development of new MHA youth protocols regarding transitions to adult sector and the treatment of youth with emotional dysregulation and suicidal ideation

6 Months:
- Finalize HHT transition model for those admitted for MHA concerns and Older Adults with MCC implementation
- Finalize HHT MHA Youth Protocols for implementation
- Begin implementation of new bed management model

12 Months:
- Standardized method developed across hospital sites to identify high service users within Year 1 population
- Wraparound transitional model of care implemented for populations leaving hospital (MHA, Older Adults with MCC)
- Creation of a city-wide bed management tool for residential and supportive housing options
- Establishment of youth MHA protocols that address: transitions to adult services, treatment of youth with emotional dysregulation and suicidal ideation
- Digital Health offerings available to patients through a variety of care settings, including patient’s ability to access their medical information digitally (e.g. KindredPHR, MyChart, MyDoveTale), ability for providers to share patient information across teams, access virtual care offerings (e.g. remote monitoring, secure messaging with care team). See Appendix B for details.

**EARLY IDENTIFICATION**

**30 - 60 - 90 Days:**
- Develop and finalize strategies for early identification within all three target populations, including selection of clinical indicators of risk.
- Develop Community of Practice for Addiction Medicine Specialists to start meeting by end of month 3
- Review referral patterns, current resource inventory and care pathways for the RAAM clinic
- Identify plan for expanding and scaling current Public Health screening tool and intervention for infants at high risk
- Identify process to identify and screen high risk families postnatally before discharge from hospital

**6 Months:**
- Develop HHT integrated care pathways to address individuals with clinical indicators of risk.
- Standardize approach for individuals requiring RAAM services
- Scale Public Health screening tool and intervention for at risk children
- Develop implementation plan for postnatal screening for high risk families

**12 Months:**
- Implement integrated care delivery models established for those identified as at risk in target populations (MHA Adults, MHA Child and Youth, Older Adults with MCC)
- Establishment of Community of Practice for Addiction Medicine Specialists in Hamilton
- Public Health screening tool has been scaled to city-led programs, child welfare teams, and EarlyON Centres
- Postnatal screening of high risk families prior to discharge from hospital is implemented
- Digital Health offerings available to patients through primary and community care settings, including patients ability to access their primary care chart digitally (e.g. KindredPHR), ability for providers to share patient information across teams, access virtual care offerings (e.g. YourSpace). See Appendix B for details.
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GEOGRAPHIC CLUSTERS

30 - 60 - 90 Days:
- Develop steering committee to focus on geographical work, comprised of all sectors to be facilitated through current Working Group structure.
- Identification of target geographical locations within the first 30 days of Year 1 and analysis of health and social wellbeing profiles.
- Complete asset map (of services) within determined geography, draw on relevant resources from all member organizations as part of redesign within first 60 days.
- Build on current successful evidence-based approaches and identify new potentials for care delivery in identified geography.
- Develop Resident Council (of individuals who live within the selected geography) and community engagement strategies to inform work and redesign within first 90 days.

6 Months:
- Begin co-design of integrated service delivery model with all involved member organizations for geographic cluster work and mental health walk-in centres (Child and Youth MHA).

12 Months:
- New service delivery model implemented in geographic cluster(s).
- New low-barrier mental health walk-in counselling centre implemented.
- On-site youth addiction services expanded into two Child Welfare Service locations.
- Digital Health offerings available to patients through primary and community care settings, including patients ability to access their primary care chart digitally (e.g. KindredPHR), access virtual care offerings (e.g. OTN eVisits), ability for providers to share patient information across teams. See Appendix B for details.

DIGITAL HEALTH

30 - 60 - 90 Days:
- Identify barriers to uptake of digital offerings among member organizations (e.g. virtual care, digitally sharing information – patients and providers).
- Develop work plan for expansion of IDS.
- Work with ClinicalConnect to improve usability, performance of platform to increase uptake (see Appendix 5, letter of support).

6 Months:
- Implement mitigation strategies to address barriers and promote uptake of existing digital tools among members (e.g. education, promotion of tools, streamlining authorization).
- Continue work with ClinicalConnect.
- Begin expansion of IDS data.
### Ontario Health Teams

#### Full Application Form

<table>
<thead>
<tr>
<th>12 Months:</th>
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<tbody>
<tr>
<td>- Increased uptake of existing digital tools among members and Year 1 patients</td>
</tr>
<tr>
<td>- Expanded IDS repository including EMS, community mental health, additional primary care data</td>
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<tr>
<td>- Increased uptake and improved performance of ClinicalConnect</td>
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#### GOVERNANCE

<table>
<thead>
<tr>
<th>30 - 60 - 90 Days:</th>
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<tbody>
<tr>
<td>- Identify resources required for HHT work</td>
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<tr>
<td>- Develop recruitment strategy for HHT staff team</td>
</tr>
<tr>
<td>- Develop communication plan and terms of reference for levels of governance, Working Groups</td>
</tr>
<tr>
<td>- Develop Criteria for HHT membership</td>
</tr>
<tr>
<td>- Develop Master Agreement, COI, Procurement and Information Sharing Agreements</td>
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<tr>
<td>- Develop strategic plan and central brand for HHT</td>
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<table>
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<tr>
<th>6 Months:</th>
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<tbody>
<tr>
<td>- Formalize Master Agreement (and associated agreements) including with Ministry for member review</td>
</tr>
<tr>
<td>- Formalize strategic plan and central brand for HHT for member review</td>
</tr>
<tr>
<td>- Hire HHT staff for operations team</td>
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<th>12 Months:</th>
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<tbody>
<tr>
<td>- Process for selection of members for Executive Committee communicated to member organizations</td>
</tr>
<tr>
<td>- Sign off of Master Agreement, corresponding agreements (e.g. procurement, information sharing, COI)</td>
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<tr>
<td>- Finalize and share strategic plan and central brand to members, collaborators, potential members, MOH, website/public</td>
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#### HOME AND COMMUNITY CARE

<table>
<thead>
<tr>
<th>30 - 60 - 90 Days:</th>
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<tbody>
<tr>
<td>- Current and future state mapping of care coordination and system navigation within Hamilton</td>
</tr>
<tr>
<td>- Work with Primary Care Working Group to target areas most in need of care coordination embedment</td>
</tr>
<tr>
<td>- Work with Geographic Cluster Steering Committee to inform care coordination redesign</td>
</tr>
<tr>
<td>- Home and Community Care Working Group to develop work plan for home and community care modernization/maturity plan</td>
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<table>
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<th>6 Months:</th>
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<tbody>
<tr>
<td>- Develop implementation plan for embedding care coordinators into primary care</td>
</tr>
<tr>
<td>- Build and scale models of integrated home and community care</td>
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</table>
12 Months:
- Target embedment of care coordination in primary care achieved
- New service model of care coordination and navigation is started in geographic cluster
- HHT Home and Community Care maturity plan developed.

6.2. What is your change management plan?
Please describe your change management strategy. What change management processes and activities will you put in place before and during implementation? Include approaches for change management with primary care providers, and how you propose to leverage clinician leaders in helping their peers to embrace and embed change.

Max word count: 1000
To ensure the most effective processes and activities are in place before and during implementation, our HHT is using an integrated approach to change. The integrated organizational change model includes consideration and planning in five domains: Strategy, Leadership, Change, Transition and Communication. An integrated approach to change focuses efforts on top priorities while supporting successful outcomes and behavioural change.

An articulated change strategy ensures that the intention is robust and the reasons for the change are clear. It also helps the HHT align priorities. Effective leadership and sponsorship of changes ensures clear oversight and management of the executed strategy. Our HHT is uniquely positioned to enable a successful cross-sectoral approach to change. Our HHT Oversight and Coordination Secretariat, co-chaired by two patient participants, meets weekly to engage in robust discussion about our HHT.

The Project Management Office (PMO) has been established to ensure effective project management processes are followed. As described above, the PMO hosted four workshops with cross representation from patient participants, acute and primary care, and community partners to build trust and relationships, foster engagement, and develop content for the Full Application.

Our HHT is also uniquely positioned to deliver on an effective change management strategy for primary care. Dr. Tammy Packer, a primary care physician member, acts as Chief, Department of Family Medicine at St. Joseph’s Healthcare Hamilton, Hamilton Health Sciences, and is the Primary Care Lead for Hamilton. This structure allows Dr. Packer access to family medicine groups at both hospitals who are actively engaged in the provision of care for our Year 1 populations. Many physicians within these groups have already expressed interest in participating in Year 1 of our HHT development and implementation and are anticipated to join in as collaborators in Year 1.
Dr. Packer continues to build buy-in with her colleagues through avenues like face to face rounds at walk-in clinics and through discussions with unaffiliated primary care physicians within our community who may not receive updates on HHT through other channels.

The change plan ensures that projects are thoughtfully actioned, with specific priorities and work plans. Between April and September 2019, primary care physicians and providers contributed to the development of our Year 1 HHT Plan (see Tables 2.1.1, 2.6.1.). These individuals also signed on to our HHT application as first wave primary care collaborators. First wave primary care collaborators are self-identified providers from across all primary care models that will continue to support our HHT implementation through to maturity. Membership includes: physicians and providers from the McMaster FHT, a subgroup of the Hamilton FHT, a number of unaffiliated Family Health Organization and Family Health Group physicians, and physicians involved with Shelter Health, Compass Community Health Centre, and Centre de santé communautaire Hamilton/Niagara.

Communication is an essential element to connect all change efforts together and communicate the vision to stakeholders. We are currently engaging the Primary Care Network Group (PCNG) which meets regularly and includes the Executive Directors, CEOs, Program Managers, and Physician Leads from McMaster FHT, Hamilton FHT, Compass CHC, Urban Core CHC, Centre de santé communautaire Hamilton/Niagara, Shelter Health, De dwa da dehs nye>s Aboriginal Health Centre and Refuge Health. This group will share information between providers and engage leaders in the development and implementation of our HHT, particularly for primary care providers who are not currently a member of the HHT. The PCNG is also actively involved in cataloguing all current resources, programs and services offered by their primary care organizations with a view to seeing what level of services can be utilized and/or expanded to assist with HHT Year 1 populations. In Year 1, the PCNG will likely serve as one of our Working Groups (see Q4.2) to help engage primary care in development and implementation. Eventually, the PCNG will serve as the organizing infrastructure for primary care within our HHT through to Maturity.

Outside of our current member primary care providers and FHTs, we will also communicate with a large group of primary care providers using our Hamilton Family Medicine (HFAM) group to keep all up to date with the progress of the HHT. For example, HFAM coordinates weekly events for the city-wide community of Family Medicine. This weekly venue will be used for periodic updates of our HHT using a town hall and/or round table format. The HFAM will also communicate HHT developments through to primary care providers using their social media accounts (both HFAM Twitter and Facebook accounts have been actively updating their members on the progress of the HHT as of July 2019).

Leading people through the transition from current to future state is an important element of the HHT’s work and stakeholder engagement. As member organizations of our HHT, two of the largest FHTs in Hamilton (McMaster and Hamilton FHT) have
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provided significant support in development of our HHT plans and will continue to provide support through implementation and collaboration by physicians and providers within their teams. More specifically, the Boards of the McMaster and Hamilton Family Health Teams expect their Lead Physicians and other members of their management teams to work in a cooperative manner with other members of the HHT in Year 1 through to Maturity to help expand services and embrace and embed change in primary care. The FHTs expect primary care engagement to take place at the practice level and each FHT is devoting significant time and resources to meet with their members to provide information about the HHT’s development and to ask for support from their physicians.

6.3. How will you maintain care levels of care for patients who are not part of your Year 1 population?
Indicate how you will ensure continuity of care and maintain access and high-quality care for both your Year 1 patients and those patients who seek or receive care from members of your team but who may not be part of your Year 1 target population.

Max word count: 500
The HHT has committed to redesigning care for our Year 1 populations through our Full Application. Member organizations and service providers will continue to work on strategic initiatives for the improvement of the health and well-being of those in our community who are not considered part of our Year 1 population. What makes the HHT so unique is that the member organizations and providers have come together for this commitment to redesign while also working together on access and continuity of care for a range of populations.

To highlight, these are some examples of integrated work underway for populations that may not be included in our Year 1 group:
• ICC Program for all planned surgical cases
• Indwell Supportive Housing: affordable housing communities with integrated supports
• Post-Acute Restore and Recover Program
• Bundled Hip and Knee Surgery Program
• Integrated Care for Dialysis

Additionally, Hamilton is home to exemplary regional acute care programs that include cancer care, pediatrics, trauma, cardiac, high-risk maternity, burn, stroke, vascular and neuro. On a daily basis, Hamilton hospitals accept patients from across the province to receive high-quality access to specialized programs.

Member organizations and providers will continue to provide the standard of care for all patients who access services. We do not anticipate our proposed integrated models of care will interfere with the ability to provide the current level of services to people who are not Year 1 populations, but are seeking our services.

6.4. Have you identified any systemic barriers or facilitators to change?
Identify existing structural or systemic barriers (e.g., legislative, regulatory, policy,
funding) that may impede your team’s ability to successfully implement your care redesign plans or the Ontario Health Team model more broadly. *This response is intended as information for the Ministry and is not evaluated.*

Max word count: 1000

Existing structural and systemic barriers have been listed throughout our Full Application. The HHT has identified the following systemic barriers:

Labour Relations: All front line resources of the LHIN (Care Coordinators and Patient Care Assistants) are unionized staff (ONA or OPSEU). Labor implications and legislative changes need to be addressed when considering the transition of any existing unionized health human resource assets under the OHT (see Appendix A).

Resources: Investments and resources in order to affect change are necessary for success. Year after year, our HHT providers are challenged to handle the demands of an aging and more complex population. As we look to target those most in need in our attributed population, the team will need financial support to achieve our outcomes. We look forward to working with the Ministry to best identify the appropriate level of financial support needed to make our OHT successful.

Home and Community Care: As identified in Appendix A, there are risks and enablers to modernizing home and community care. The HHT strongly believes home care services should be aligned with our OHT directly. Including the full scope of services such as service provider contracts, procurement, care coordination and staffing within the HHT oversight will be key enablers to success moving forward. The HHT will be seeking preferred Agency status so we can design and align existing home care delivery and maximize efficiency and positive outcomes. The HHT will work with the Ministry to expedite this process.

Appropriate Community Capacity: Appropriate capacity for patients to thrive within the community will enable success through our integrated care models and reduce hallway medicine. Without the appropriate resources in the community, our hospitals may not have effective discharge locations for some patients. The following resources would enable our success in Year 1 through to Maturity:

-- Housing: There is a current housing shortage in Hamilton that includes access to affordable housing. Without access to affordable and/or supportive housing, some patients remain in hospital despite no longer requiring hospital-level care. Additionally, housing will help precariously housed and homeless individuals find long-term housing solutions to help improve their wellbeing.
Long-Term Care: Long-Term Care bed access remains one of the most significant flow barriers to transitioning patients from hospital to their most appropriate care environment. This is further exacerbated by the ability of patients to wait for their first choice of home while in the hospital or community. This is putting a strain on hospitals to create flow for incoming patients and puts additional strain for caregivers in the home assisting those waiting for a long-term care bed to be available.

Bariatric and Behavioural Supports: There is a lack of appropriate spaces within the community for bariatric patients and patients requiring behavioural supports. Patients requiring this level of care often stay in the hospital for years due to lack of availability within the community. This lowers the patient’s quality of life and exacerbates the lack of capacity within our hospitals. Additional bariatric and behavioural supports within the community are required to help these patients receive care in a more appropriate place and reduce hallway medicine.

Transportation: Cost of transportation and lack of informal/formal support for complex patients who are required to attend appointments with multiple care providers results in the non-attendance and therefore non-compliance with poor outcomes.

Policy and Legislative Barriers: there are numerous policy and legislative barriers that create systematic obstacles for our Year 1 target populations specifically:

Age Restrictions: The child and youth mental health core service providers are permitted to provide service to children and youth up to the age of 18 (as per Program Guidelines and Requirements #01: Core Services and Key Processes). The expectation is discharge (with transition to adult services where required) at this critical period of time. This can create significant barriers for young people trying to access service close to their 18th birthday, as well as transition points at a vulnerable period of time.

Privacy and Consent: There are a number of competing pieces of legislation, with often different interpretations, which impact community based services, including child and youth mental health core services and education services. The challenges include interpretations re: age of consent, the need for parental consent when the child/youth may be accessing service independently (this practice is variable), and “circle of care” practices. The competing and/or challenges pieces of legislation include the Child, Youth and Family Services Act, 2017, the Education Act, 1990, and the Personal Health Information Protection Act, 2004.

Long-Term Care Homes Act, 2007: Patients and substitute decisions makers have
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A choice whether to select or decline admission to a long-term care home (LTCH) facility, some will opt to stay in hospital until their first choice comes up and/or do not believe the community can manage their care needs like the hospital. This creates a very substantial flow problem in the hospital as patients wait for their first choice. This is one significant cause of hallway medicine in Hamilton, as patients waiting for LTCH beds occupy a bed in hospital for longer than needed, thus creating less capacity to handle new patients accessing the hospital.

-- Ambulance Act, 1990: Under the Ambulance Act, paramedics are currently unable to transport to other locations other than a hospital. There needs to be alternate transportation options for patients who would benefit from a different level care. Hamilton EMS consistently transports the highest number of patients to local emergency departments, putting increased stress on an already over-capacitated local hospital system. Having an option to transport to another appropriate facility or care practitioner would help ease this pressure.

These barriers and associated risks to our Integrated Models of Care are further detailed with mitigation strategies in Table 6.6.

6.5. What non-financial resources or supports would your team find most helpful?
Please identify what centralized resources or supports would most help your team deliver on its Year 1 implementation plan and meet the Year 1 expectations set out in the Guidance Document. This response is intended as information for the Ministry and is not evaluated.

Max word count: 1000
The HHT has identified several non-financial resources and supports that would assist in meeting our Year 1 expectations.

The development of a province-wide OHT Community of Practice (including approved OHTs and RISE) will assist in understanding local and provincial strategies in OHT implementation. Aligning strategies, understanding homecare redesign options and should not be done in a siloed approach, but rather as a collaboration to create a consistent and cohesive system across the province for patients, families, and caregivers.

The provision of a provincially organized human resources strategy for the PSW shortage is essential. Implementing our integrated care models will be enabled by a robust approach to employ and retain a healthy workforce to take care of our most at-risk populations. Without the human health resources in the hospital and community, we will not be able to meet our Year 1 goals.
Support related to data, emerging research and evidence would be beneficial to support the planning and implementation of initiatives. Continued access to RISE through the implementation stages and Ministry related data in real time will help to guide intervention development.

6.6. Risk analysis
Please describe any risks and contingencies you have identified regarding the development and implementation of your proposed Ontario Health Team. Describe whether you foresee any potential issues in achieving your care redesign priorities/implementation plan or in meeting any of the Year 1 Expectations for Ontario Health Team Candidates set out in the Guidance Document. Please describe any mitigation strategies you plan to put in place to address identified risks.

As part of your response, please categorize the risks you’ve identified according to the following model of risk categories and sub-categories:

<table>
<thead>
<tr>
<th>Patient Care Risks</th>
<th>Resource Risks</th>
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<tbody>
<tr>
<td>• Scope of practice/professional regulation</td>
<td>• Human resources</td>
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<tr>
<td>• Quality/patient safety</td>
<td>• Financial</td>
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<tr>
<td>• Other</td>
<td>• Information &amp; technology</td>
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<td>• Other</td>
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<tr>
<th>Compliance Risks</th>
<th>Partnership Risks</th>
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<tr>
<td>• Legislative (including privacy)</td>
<td>• Governance</td>
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<td>• Regulatory</td>
<td>• Community support</td>
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<tr>
<td>• Other</td>
<td>• Patient engagement</td>
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<td></td>
<td>• Other</td>
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<thead>
<tr>
<th>Risk Category</th>
<th>Risk Sub-Category</th>
<th>Description of Risk</th>
<th>Risk Mitigation Plan</th>
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</table>

See supplementary Excel spreadsheet

6.7. Additional comments
Is there any other information pertinent to this application that you would like to add?

*Max word count: 500*
7. Membership Approval

Please have every member of your team sign this application. For organizations, board chair sign-off is required.

By signing this section, you indicate that you have taken appropriate steps to ensure that the content of this application is accurate and complete.

<table>
<thead>
<tr>
<th>Team Member</th>
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<tr>
<td>Name</td>
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<td>Organization (where applicable)</td>
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*Please repeat signature lines as necessary (See supplementary Excel spreadsheet)*
Ontario Health Teams will help to modernize home and community care services, so patients can live at home longer, return home more quickly from hospital, or delay or avoid the need for admission to a hospital or a long-term care home.

In this section, you are asked to outline a long-term vision for re-designed home and community care model and a short-term action plan with immediate priorities. Your team is encouraged to consider how you will improve the patient and provider experience, better integrate home and community care with other parts of the health care system and improve the efficiency of home and community care delivery. For Year 1, you are asked to propose a plan for transition of home and community care responsibilities to your Ontario Health Team.

Your proposal should demonstrate how you plan to re-imagine and innovate in home and community care delivery, while ensuring efficient use of resources. Your team’s proposal will help the Ministry understand how to better support innovative approaches to home care. The Ministry is exploring potential legislative, regulatory and policy changes to modernize the home care sector so that innovative care delivery models focused on quality can spread throughout the province.

Responses provided in this section will be evaluated based on how well your team understands the home care needs of your Year 1 and maturity populations and opportunities for improvement and how well your proposed plan aligns with the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management.

A.1. What is your team’s long-term vision for the design and delivery of home and community care?

Describe your long-term vision for how you will modernize and better integrate home and community care taking into consideration local population needs and local challenges in home and community care.

Highlight proposals to strengthen innovative service delivery, increase accountability for performance, and support efficient and integrated service delivery.

Max word count: 1500

The HHT is fortunate, in that there is significant experience and demonstrated performance improvements associated with the implementation of a number of modernized and holistic models of care. These models reflect cross sector collaboration and strong alignment with the Quadruple Aim. Spread and
enhancement of these models coupled with the introduction of new targeted approaches will ensure that at maturity, patients will experience a seamless continuum without fragmented transitions between primary, community, acute and home care services.

HHT member organizations have developed a long-term vision for the design and delivery of home and community care that has been established according to the following guiding principles:

• Home and Community Care services will be integrated under one team with single governance, one record and one number to call;
• New models must support and reflect the needs of Francophone, Indigenous, diverse and marginalized populations;
• Health and social services must be embedded into redesign;
• Redesign must result in a seamless patient centered care continuum;
• Health and social information will be integrated and shared amongst providers and patients;
• Patients must receive improved and streamlined access to care and services;
• All actions will be aimed at improving quality of life;
• Unwanted variations and redundancy in patient care will be reduced;
• All efficiencies amongst providers will be captured within the integrated care team;
• Provider work life should be enhanced;
• Caregiver needs must be recognized.

Despite substantive legislative and policy barriers, many providers have been working together collaboratively to deliver cohesive care that already incorporates elements such as: one lead service provider agency, 24/7 access, sharing of client information, integrated delivery models focused on target populations, and shared accountability. Current modernized models of care already underway include:

1. Integrated Comprehensive Care Models (ICC)
ICC is an evidence-based model of Bundled Care that supports patients with One Team, One Record, One Number to Call, 24/7. The focus is to make the patient experience as seamless as possible, while utilizing existing financial, human and technology resources across the continuum, to deliver an integrated and comprehensive care experience. Integrated funding is a key enabler for system redesign; it aligns the right incentives, empowers stakeholders and drives value across the full episode of care. Experience with ICC includes support for planned surgeries, COPD and CHF pathways. The learnings from the ICC model development in chronic disease will directly inform the design of pathways for seniors with multiple chronic conditions.

2. Embedding Home and Community Care Coordinators in Primary Care
The embedment of HNHB LHIN Care Coordinators into Primary Care settings started in 2018. Through the establishment of collaborative working relationships, LHIN Care Coordination has been successfully transitioned into eight primary care settings:
McMaster FHT, Hamilton FHT, Compass CHC, Urban Core CHC, Centre de santé communautaire Hamilton/Niagara, De dwa da dehs nye>s Aboriginal Health Centre, Shelter Health Network and the Regional Geriatric Program. Co-locating Care Coordinators in primary care settings has resulted in a patient and family centered approach that coordinates health and social services for diverse populations through collaboration amongst inter-professional teams. Considering the needs of Indigenous, Francophone and other unique populations will be critical in promoting health equity and access to care for all. The HHT will build upon this success and continue to bring care coordination closer to primary care as a Year 1 goal.

3. Integrated Hospice Palliative Care Teams
The HNHB LHIN supports an Integrated Hospice Palliative care team model across the LHIN. The Palliative Care Outreach Teams (PCOT) is a group of specialist providers from multiple organizations who practice as an inter-professional team. The PCOT teams have shared accountability with primary care for patients requiring a palliative approach to care. The teams are a source of expert advice and consultation that provide specialist palliative care services for patients with complex needs in their homes or place of residence. Partnerships in Hamilton include: HNHB LHIN, Bob Kemp Hospice, Emmanuel House, Hamilton FHT, HOPE, and Palliative Physician Specialists.

4. Integrated Hospital Discharge Planning Models
Currently the acute care Hamilton Hospitals have Integrated Managers of Transitions (IMT) with dual reporting and shared accountability to both the hospital and LHIN; the IMT is responsible for the LHIN home and community care team and collaborates with the hospital team to support discharge planning and transitions into the community with LHIN supports (e.g. home care, day programs) or to bedded programs (e.g. Long Term Care, Transitional Care, Convalescent Care, Rehabilitation, and palliative/hospice beds).

5. Community Services PSW collaborative - PSW Hub Model
The Home and Community Collaborative program has been in existence since 2015. It is a partnership between LHIN Home and Community Care and five partner agencies in the Hamilton area (Capability, Able Living, Good Shepherd, St. Joseph’s Home Care, March of Dimes Hamilton) focused on providing mainly personal support to 900 patients in the Hamilton area with low to moderate care needs. Stakeholders been meeting together with the CSS leadership and the SPO leadership to try and standardize care delivery for PSW in the community (scheduling, allocation, tasks) to be operationalized in the fall of 2019. Work is underway to streamline the assessment, referral and communication process to be more efficient for patients and staff.

6. Admission Avoidance
A robust admission avoidance process has been in place at SJHH since November 2015. This process includes an interdisciplinary task group consisting of members from LHIN homecare, St. Joseph’s Home Care and members of the hospital to wrap
around services around the frail elderly that did not require admission for an acute medical reason. Having the ICC St. Joseph’s Home Care resources available also added a layer that allowed the team to utilize home care resources should they not be available from the LHIN. All team members were provided access to the St. Joseph’s Home Care homecare platform which allowed for streamlined documentation and communication amongst all members of the team. A key component of the program is that patients were supported by ICC resources for 48 to 72 hours post discharge, including nursing and PSW support. Patients also received a phone call post discharge to review the care plan. Caregivers were also assessed if present, to understand and help inform next steps.

7. Interdisciplinary Centralized Care and Transition Team
The CCaTT is an interdisciplinary team positioned at HHS’ Hamilton General and Juravinski hospitals. Partnering with patients and other providers, the CCaTT assesses patients who are frail in the EDs and develops plans to support discharge to community thereby avoiding admissions. In addition, the CCaTT provides intensive case management for patients admitted who are identified as frail and at-risk for longer length of stay, ALC days and fragmented transitions that can result in adverse events including ED re-visits and hospital admissions. A key barrier to admit avoid is lack of timely access to services in the community to support frail adults experiencing an ambulatory sensitive care condition and who are socially isolated. To address this barrier, plans are underway to partner with a Home Care Agency who will provide same day in-home assessment and provide the required services to support the patients’ recovery for up to 7 days. This newly expanded model of care will begin to address some of the current challenges.

8. Hospital 2 Home (H2H)
HHS’ H2H team is an interdisciplinary team partnering with patients in their homes to develop coordinated care plans based on what is most important to the patient and what is most concerning to the patient about their health. The H2H team utilizes Ontario’s Health Links Model of Care to guide practice, and partners with health, social and community services providers to develop action plans helping patients achieve their goals. The H2H team has partnered with AbleLiving and Capability for the last three years to support patients and has proven to increase the potential for successfully anchoring patients into their community. The team views patients through a trauma informed care lens and utilizes motivational interviewing skills to develop true partnerships with patients. Assessments such as health literacy, cognition, depression and frailty are completed to understand patients’ unique needs, including their ability to self-manage chronic conditions.

Further expansion of these models is a commitment of the HHT and is already underway. Co-designing and testing a new service delivery model outside of the construct will be a focus of Year 1, as described below. This testing will help inform the long-term vision for Home and Community Care as we move forward with remodelling health and social care and service delivery based on the unique needs of those that live within Hamilton. A further commitment of the HHT is to gain a more
fulsome understanding of all health and social care services occurring in each of our three pillars of focus: primary, community and acute. Providers from all sectors have been fully engaged through this process, and have committed to work with one another moving forward in a redesign that includes services funded from a variety of sources. This commitment will lay the groundwork for transforming our local model to meet the needs of patients, caregivers and service providers.

A.2. What is your team’s short-term action plan for improving home and community care in Year 1?

Identify your top priorities for home and community care in your first 12 months of operation.

- What proportion of your Year 1 population do you anticipate will require home care? For this proportion of patients, describe patient characteristics, needs and level of complexity.
- Describe how you will innovate in the delivery of care to improve the delivery of home and community care to achieve your Ontario Health Team quadruple aim objectives.
- Outline a proposed approach for how you will manage patient intake, assess patient need, and deliver services as part of an integrated model of care. If relevant use the optional table below to describe the delivery model.

<table>
<thead>
<tr>
<th>Role/Function</th>
<th>Organization</th>
<th>Delivery Model (What type of provider (dedicated home care care coordinator, FHT allied health professional, contracted service provider nurse, etc) will be providing the service and how (in-person in a hospital, virtually, in the home, etc.))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing intake</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing clinical treatment/care plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivering services to patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add functions where relevant</td>
<td></td>
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</tr>
</tbody>
</table>

See supplementary Excel spreadsheet

Max word count: 1000

As highlighted within our Full Application, our Year 1 populations are complex and
require integrated wrap around care across providers and sectors. Therefore, we can predict that all of our Year 1 population will need various intensities of care coordination and system navigation that addresses both health and social needs. The patient population is constantly in flux, therefore, the HHT commits to having a coordination and navigation system in place that is constant, reliable, proactive, and applies integrated cross-sector approaches to optimize the health and well-being for our most at risk populations.

The HHT has identified three main priorities for short-term action in Year 1:

1) Target Population Service Model (deliverable for geographical target populations): Test of change with service delivery model in target geographic cluster. Benefits include:
- Opportunity to co-design new model of care for those most in need as identified by Code Red and IDS reports.
- Integrate multiple service providers touching the same patient population; engage with providers in a different way. The HHT will explore a new and integrated HHS business model to oversee/deliver Home and Community Care services with one shared health record and one number to call.
- Redesign care coordination to provide health and social care services for the identified geographic cluster.
- Address sub-optimal health outcomes, poor patient experience and high health care utilization in key areas applying a social determinants of health lens.
- Reduce duplication and improve efficiencies amongst partners
- Enhance virtual care opportunities
- Standardize a 24/7 access model.

2) Redesign a common care coordination vision (deliverable at scale): This includes:
Embeding care coordinators in primary care; Continuing to integrate care coordinators within hospital teams; Defining care coordination across the system, and undertake a mapping of all existing coordinated care services and tools (such as self-management apps etc.); Completing gap analysis of care coordination across all sectors (primary, community and acute); Integrating or aligning social/community and health care services where possible. Benefits include:
- Co-design a common care coordination vision
- Move coordination of care closer to primary care, establish trust and relationships
- Bridge transitions along the system in a more effective way (hospital, community, primary care)
- Integrate social and health navigation
- Provide patients with a single point of contact for hospital discharge planning
- Reduce duplication and increase efficiencies and standardization across discharge planning roles/functions

3) Map out a Future Home and Community Care Operating Model (to work towards maturity): This includes the following:
- Identify, map and plan a future home and community care operating model that
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<table>
<thead>
<tr>
<th>leverages all assets in the City, and takes into account the needs of priority populations, including Indigenous, Francophone, and people living in high poverty neighborhoods.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Set the foundation, using principles co-designed by the HHT to redesign home and community care for residents in Hamilton.</td>
</tr>
<tr>
<td>- Continue to build and scale models of integrated home and community care already underway in Hamilton.</td>
</tr>
<tr>
<td>- Monitor home-care performance to support rapid learning and improvement.</td>
</tr>
</tbody>
</table>
A.3. How do you propose to transition home and community care responsibilities?

Please describe your proposed plan for transiting home and community care resources to your Ontario Health Team in Year 1, such as care coordination resources, digital assets, programs, and local knowledge and expertise.

Max word count: 1000

The HHT organizations have set a number of Year 1 priorities that relate to care coordination, redesigning a new service delivery model and committing to co-designing a new future of home and community care delivery that encompasses health and social services under one umbrella.

During Year 1, the Hamilton Health Team will continue to build upon the collective expertise developed locally to further integrated care models. This expertise of community, hospital, and LHIN providers has already been demonstrated in developing models such as ICC for COPD and CHF, ICC for planned surgical patients, bundled hip and knee models and Hospital 2 Home. Transition work is very much already underway in Hamilton, under the following areas:

1) St. Joseph’s Healthcare Hamilton and ICC secondment work with care coordinators;
2) HHS’ Hospital 2 Home;
3) HHS’ Centralized Care and Transition Team;
4) Integrated Transitions Management models with the acute hospital sites comprised of LHIN and hospital employees;
5) Currently utilizing digital assets and structures through the ICC and Hospital 2 Home programs (i.e. inputting ICC patients into CHRIS system, coordinated care planning through Hospital Partner Gateway, ClinicalConnect, OTN ); and
6) Memorandum of Understanding’s have already been developed across all hospital sites in the HNHB LHIN with St. Joseph’s Home Care to facilitate integrated care through ICC 2.0 for CHF and COPD patients

Before any formal transition of home and community care resources can be started, an understanding of the substantial, non-homogenous home care structure that is currently in place needs to be understood. This work has already begun, by bringing together health and social service providers and the municipality under one Secretariat to start the redesign. An integral portion of Year 1 work will be to understand what home care structures are critical to the local HHT and what remain more central. Understanding the scope of other OHT work in neighbouring areas will be helpful to inform the longer term vision for the attributed population to the Hamilton Team.

A.4. Have you identified any barriers to home and community care modernization?
Identify any legislative, regulatory, policy barriers that may impede your team’s vision for modernizing home and community care with regards to improving health outcomes, enhancing the patient and provider experience, and ensuring system sustainability. *This response is intended as information for the Ministry and is not evaluated.*

Max word count: 1000

A new design and accountability model is preferred for our future state but the HHT is familiar with innovative ways to overcome some of the current system barriers to homecare modernization. The Protocol for Ministry Approval for a Hospital to Provide Home Care Services as part of Bundled Care Program has been utilized in Hamilton as a starting point for home care resign. At the current time, St. Joseph’s Healthcare Hamilton has approval from the Ministry under this protocol to provide homecare services.

The HHT strongly believes homecare services should be aligned with our OHT directly. Including the full scope of services such as service provider contracts, procurement, care coordination and staffing within the HHT oversight will be key enablers to success moving forward. The HHT will be seeking preferred Agency status so we can design and align existing home care delivery and maximize efficiency and positive outcomes. The HHT will work with the Ministry to expedite this process.

The HHT has identified many barriers that impede the modernization of home and community care in its current state. These barriers can be broken down into the following categories:

Health Human Resources (HHR):
• HHR Capacity issues within the home and community care sector continue across all disciplines
• Personal Support Worker and Nursing shortages specifically are becoming worse and more prevalent
• HCC Care Coordinator shortages in hospitals
• There continues to be a high demand for home care in the community
• The need for specialized training and enhanced skill set for healthcare professionals to care for certain patient populations (i.e. those with multiple chronic conditions, frailty, dialysis, complex post-surgical care)
• Shift in home and community care culture to adopt a more holistic approach and focus on person-centred care that includes the social determinants of health

Funding:
• It is unknown if the current funding model based on patient complexity (using the RAI) tool will continue.
• How will funding be allocated if each region is determining their own means of patient assessment for complexity?
• The current contract model impedes the team’s ability to change the current service delivery of home and community care.
• Funding flow for social services is across multiple ministries.
• Harmonizing pay scale may contribute to significant cost increases.
• There are challenges with resources and funding when it comes to implementing bundled care models.

Labour Contracts/Unions:
• All front line resources of the LHIN Care Coordinators and Patient Care Assistants) are unionized staff either with ONA or OPSUE. Labor implications and PSLRTA legislative changes need to be addressed when considering the transition of any existing unionized HHR assets under the OHT
• Implications of differing pay scales.

Home and Community Services Act:
• The current contracted service provider model which is primarily based on a pay per visit structure is expensive, inefficient and has risks and limitations in achieving patient outcomes
• The current LHIN care coordination scope is limited as per the legislation. Patients could benefit from strictly care coordination or navigation that is not necessarily triggered by a need for a health service.
• Currently only the LHIN can assess, determine eligibility and establish a care plan for patients who will receive services from a contracted LHIN service provider, unless one has undergone the approved agency process.

Priority Populations:
• There is a lack of reliable information from service providers about Francophone and Indigenous patients. This lack of information creates difficulty assessing the need for culturally specific and language specific services.
• Underreporting of Indigenous health information.
• The commitment to ask people if they need services in French (active offer) and have a robust external referral mechanism in place (if such services are unavailable in-house) is crucial. Only identifying Francophone people without having a clear plan and process in place makes it as such that people continue to be identifying as Anglophone and do not receive the most appropriate care and resources.

CHRIS Platform:
• Unknown Provincial direction of CHRIS platform utilization makes it difficult to understand what electronic tool will be used moving forward as the contracted service provider interface for the delivery of in home services as well as the tracking and documentation of current home care delivery
• There are privacy challenges in the current state of allowing other providers outside of the LHIN to use CHRIS.

Provincial Direction:
• There is difficulty in planning a long-term vision when it is unknown what functions of home and community care delivery may remain with Ontario Health versus local Ontario Health Teams
• Before we can know how to transition assets, the Hamilton Health Team needs to understand more specifically the provincial direction and responsibilities of home care in the Ontario Health Team model.
• There are risks for local Ontario Health Teams to plan home and community care delivery only for their targeted population, when patients are known to cross borders.

Current Assessment Tools:
• The RAI tool can be cumbersome, there are other tools available, with good evidence that could provide the same results for care and service planning.
• There is a need to reduce redundant steps, reduce assessment burden in the system and streamline assessments, documentation, and communication.
• There is a risk with eliminating the RAI HC tool as it is currently used to guide Ministry funding for Home Care and would need to be replaced with an alternate methodology for determining funding distribution across the province with respect to in home services.
APPENDIX B: Digital Health

Experience from other jurisdictions suggests that digital health is a powerful tool for advancing integrated care, shared accountability, value-based health care, and population health management approaches.

In this section your team is asked to assess its current digital health capabilities and propose plans for building off this existing capacity to meet the minimum readiness requirements and Year 1 expectations set out by the Ontario Health Team Guidance Document. Responses provided in this section will be evaluated based on the degree to which your team seeks to integrate already existing infrastructure and improve disparities in digital capacity across the members of your team. Responses will also help the Ministry understand what supports teams may need in the area of digital health.

By completing this section, the members of your team consent that the relevant delivery organizations (i.e., Cancer Care Ontario, Health Shared Services Ontario, Ontario MD, Ontario Telemedicine Network, and/or eHealth Ontario) may support the Ministry of Health’s (Ministry) validation of claims made in the Current State Assessment by sharing validation information (e.g., the number of EMR instances, including the name and version of all EMRs used by applicants) with the Ministry for that purpose.

B.1 Current State Assessment

Please complete the following table to provide a current state assessment of each team member’s digital health capabilities.

<table>
<thead>
<tr>
<th>Member</th>
<th>Hospital Information System Instances</th>
<th>Electronic Medical Record Instances</th>
<th>Access to other clinical information systems</th>
<th>Access to provincial clinical viewers</th>
<th>Do you provide online appointment booking?</th>
<th>Use of virtual care</th>
<th>Patient Access Channels</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Identify vendor and version and presence of clustering</td>
<td>Identify vendor and version</td>
<td>E.g., Other provincial systems such as CHRIS, or other systems to digitally store patient information</td>
<td>ClinicalConnect or ConnectingOntario</td>
<td>ClinicalConnect or ConnectingOntario</td>
<td>ClinicalConnect or ConnectingOntario</td>
<td>ClinicalConnect or ConnectingOntario</td>
</tr>
</tbody>
</table>

See supplementary Excel spreadsheet
B.2 Digital Health Plans
Where gaps are identified through the current state assessment, the plans below should include an approach for addressing these gaps. As you articulate your plans please identify what non-financial support and services you will require from the Ministry or delivery organizations.

2.1 Virtual Care
Describe your plan for how you will build off your team’s existing digital capabilities to further expand virtual offerings in Year 1. If some or all of the members of your team do not have virtual care capacity, what steps will you take to ensure that by the end of Year 1 your team offers one or more virtual services? Provide an assessment of how difficult it will be for your team to meet the following target: 2-5% of Year 1 patients who received care from your team had a virtual encounter in Year 1. Describe how you will determine whether your provision of virtual care is successful or not (e.g., measures of efficacy or efficiency).

Max word count: 1000
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.

Expanding Current Virtual Care Offerings
Using our current virtual care capabilities, we hope to expand virtual care offerings to our Year 1 patient populations. The following virtual care options are currently used by some of our member organizations and their use will be promoted and expanded across HHT members in Year 1:

SMArTVIEW: SMArTVIEW is a first-in-kind hospital-to-home program providing remote automated monitoring, virtual recovery support and clinical management, and self-management wellness training. SMArTVIEW aims to reduce hospital readmission, ED visits, postoperative complications and mortality, improve patient quality of life, functional status, and satisfaction with care, and promote cost utility and effectiveness. Our HHT member organizations and collaborators are currently using/operating SMArTVIEW (McMaster University, OTN, Hamilton Health Sciences). We will continue to promote and expand use of this service to our Year 1 population of Older Adults with MCC recovering from surgery.

My DoveTale: Using My DoveTale, patients are able to access virtual care in hospital clinics, including in Mental Health,
the Firestone Respiratory Clinic, and Kidney Transplant and Nephrology. This virtual care offering is provided through HHT member organization St. Joseph’s Healthcare Hamilton (SJHH) and is completely embedded in the hospital’s information system (HIS). Using this platform, providers are able to schedule virtual visits within the HIS alongside in-person visits and document in real time during the visit. SJHH has a wealth of experience in establishing a virtual care program and will bring this to the HHT to assist other sites with establishing virtual care offerings. Currently 4% (n=143) of patients in clinics that offer virtual care options. We will continue to promote and expand use of this service to our Year 1 population of Adults with MHA concerns and Older Adults with Multiple Chronic Conditions.

kindredPHR: A citizen-controlled personal health record with which the McMaster FHT has integrated its EMR to facilitate real-time on-line booking, appointment notifications, secure messaging, data sharing and completion of secure electronic questionnaires by patients. As a member of our HHT, McMaster FHT’s patients will have access to this service, including many patients within our Year 1 populations.

Livecare Connect: A proven telemedicine platform for video and secure messaging visits that is integrated with OSCAR (clinician EMR) and kindredPHR (citizen personal health record) currently used by the McMaster FHT, and can be used as a standalone platform in tandem with other EMR or HIS systems. Currently, patients from the McMaster FHT use secure messaging through kindredPHR which will be enhanced with the option of video visits via Livecare Connect. Livecare Connect improves access, timeliness, integration and experience for patients and can be shared with interested primary care providers beyond the McMaster FHT to enhance primary care’s support of all relevant Year 1 target populations.

YourSpace: An online resource for youth and their families to access mental health information and supports in Hamilton. Supports provided include live online sessions for youth and family, where facilitators share mental health facts including help for coping, and simple ideas for taking care of oneself. This program is supported by many of our member organizations including Lynwood Charlton, City of Hamilton, HHS, Thrive, SJHH, and Good Shepherd. We will continue to promote and expand use of this service to our Year 1 population of Children and Youth with Mental Health and Addictions concerns.

Provincial Virtual Visit Program: Many of our member organizations already work with OTN to provide virtual visits to their patients. In Year 1, we will explore opportunities for expanding the Provincial Virtual Visit Program across HHT member organizations that are eligible for OTN membership.
Despite virtual care not being available from all organizations, we do not foresee any challenges with 2-5% of our target populations accessing some form of virtual care in Year 1. Many of the virtual care offerings already provided in the acute, primary care, and community sectors have uptake of at least 2-5% among patients.

Barriers to Uptake

As an HHT we are also committed to identifying barriers to access and uptake of virtual care offerings among all member organizations in Year 1 and will determine which virtual care offerings are appropriate within specific care and service settings. We will work with our member organizations and the Ministry to address these barriers from Year 1 through to maturity. In addition, we will continue to use the Ministry’s Digital Health Playbook to guide us during development and implementation of virtual care offerings through leveraging existing provincial assets appropriate for our HHT members.

Virtual Care Evaluation

Our HHT will evaluate the effectiveness of our virtual care offerings in Year 1 for both patients, clients, families, caregivers, and providers by assessing satisfaction, health outcomes, and efficiency to ensure they are appropriate for our patients and providers. This will be done through continued evaluation strategies already in place for our virtual care offerings. OTN's data-related services are also available in support of the HHT to track and report on the use of virtual visits.

2.2 Digital Access to Health Information

Describe your plan for how you will build off your team’s existing digital capabilities to provide patients with at least some digital access to their health information. Provide an assessment of how difficult it will be for your team to meet the following target: 10-15% of Year 1 patients who received care from your team digitally accessed their health information in Year 1.

Max word count: 1000

Through ongoing deployment of MyChart, MyDovetale, kindredPHR platforms, our HHT will build on existing digital capabilities to provide at least 10 – 15% of our Year 1 population with digital access to their health information.

MyChart is an online portal that enables patients to register for an account that provides 24-7 online access to their health records, and ability to self-enter health information, view education materials, and delegate access to caregivers, family,
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and healthcare providers (hospital clinicians, primary care physicians, home care, and pharmacists). MyChart is currently used by HHS.

My Dovetale is a patient-centred portal and mobile app that gives patients, families and caregivers the opportunity to view health information, message with their care team, video conference, and request, view and cancel appointments. My Dovetale is currently used by St. Joseph’s Healthcare Hamilton and St. Joseph’s Home Care.

KindredPHR is a citizen-controlled personal health record developed by McMaster University that enables each person to bring their personal network, providers (health and community services), monitoring tools and resources (care plans and educational documents) together in one, secure virtual place. When integrated with a provider system, kindredPHR can facilitate on-line booking and appointment notifications, secure messaging, electronic survey completion and data sharing, and with patient permission enables providers to contextually launch the PHR record from within the EMR. McMaster FHT has integrated its EMR (OSCAR) with kindredPHR.

With current uptake of MyChart, My Dovetale, and KindredPHR, we do not anticipate any challenges in providing digital access to health information through our current platforms for 10-15% of our Year 1 population.

In addition, to ensure current platforms are expanded and scaled to all patients and providers within our HHT by maturity, in Year 1 we will address barriers and promote the use of these platforms with additional providers and Year 1 patients within our team through the following initiatives:

Increase Education: Organizations within our HHT have identified privacy concerns as a barrier to patient uptake of accessing their information digitally. In Year 1, HHT will provide education on how health information within our platforms is kept private and secure to providers and patients to promote uptake of digital access.

Promote Registration: HHT will also promote awareness and registration for platforms to both providers and patients. These three platforms were introduced between 2017 and 2019; additional push for registration is likely to increase uptake over Year 1 of the HHT to maturity. (Note that uptake of MyChart among providers will also depend on uptake of ClinicalConnect as MyChart uses data contained within ClinicalConnect. Our HHT also has plans to increase uptake and expand use of ClinicalConnect among all providers within our HHT by maturity (see QB2.3)).

Streamline Authorization: Several digital platforms require users, organizations to go through authentication. When several
platforms are required, separate authentication for each is cumbersome. Additionally, there is also often lag in receiving access from administrator of platform (e.g. up to 4 months for MyChart / ClinicalConnect).* Streamlining and consolidating authorization to platforms would reduce burdens on organizations who sign up for multiple platforms. In Year 1, we are committed to working with digital platforms to streamline authorization processes and consolidate agreements where appropriate.

2.3 Digitally Enabled Information Sharing
Describe your plan for ensuring that patient information is shared securely and digitally across the providers in your team for the purposes of integrated care delivery, planning (e.g., pooling information to understand population health needs and cost drivers, population segmentation, integrated care pathway design).

Max word count: 1000

In Year 1, we plan to expand existing digital health assets to meet our short-term objective of supporting information sharing across members of our team. More specifically, we will do this through expanding existing system resources that are scalable through to maturity to promote value and efficiency of services.

(1) ClinicalConnect

ClinicalConnect is a secure, web-based portal that provides authorized providers with real-time 24-7 access to their patients' electronic medical information including historical data from acute care settings, oncology, and home and community care records. ClinicalConnect also aggregates data from five provincial repositories and launches from various primary care point of service systems enabling providers to share data amongst themselves to optimize healthcare delivery, patient care, and safety.

Through the ClinicalConnect platform, shared information among providers from various care sectors has helped reduce duplication of tests and procedures, saving time, discomfort and cost for patients and the health system. It has also improved coordination of care between healthcare providers and improved patient safety and quality of their care. Nine of our HHT member organizations are already using ClinicalConnect. In Year 1 of HHT, we plan to increase uptake of ClinicalConnect to additional care sectors to build a more fulsome repository of information for providers accessing and sharing patient data. To do so, we will address barriers and continue ongoing initiatives to increase uptake, including:

Expand Primary Care Data Sharing (PCDS) Initiative: The PCDS is a time-limited multi-phase Proof of Concept supported
by eHealth Ontario, OntarioMD, Ministry, and HITs eHealth office. Since 2017, PCDS has resulted in the development of a standardized primary care data set that includes a core set of demographic data and subset of cumulative patient profile information (allergies, risk factors, medications, medical history, etc.) within ClinicalConnect. Access to this information has enhanced clinical decision making, patient management, transitions, and safety, and reduced the need to request external information and benefited both Primary Care providers and patients. This proof of concept has increased uptake of ClinicalConnect within the primary care setting and continuing this module through Year 1 to Maturity will help HHT increase uptake of ClinicalConnect among primary care providers. (Note: This initiative is dependent on ongoing support from the Ministry of Health).

Improve Performance and Usability: Through our HHT working sessions, various providers from different sectors have identified performance and usability issues with ClinicalConnect outside of the hospital sector. Our HHT is committed to working with ClinicalConnect in Year 1 to improve performance and usability to increase uptake in the community and primary care sectors. See appended letter of support from ClinicalConnect who have committed to working with HHT to address performance and usability issues in Year 1 through to maturity.

Introduce Incentives (Contextual Launch, Push Notifications): HHT will also work with ClinicalConnect to create contextual launch capabilities and push notifications outside of the hospital setting. This feature would incentivize primary care and community providers to use ClinicalConnect within their practices. See appended letter of support (Appendix 5).

(2) Secure Messaging

In Year 1, our HHT plans to obtain a secure messaging (SM) platform to be used by all members. The use of SM will provide health care providers with technology that will facilitate communication among members resulting in improvement in the efficient and safe delivery of excellent care. More specifically, an SM solution will:
• Facilitate staff being able to securely communicate to their colleagues electronically
• Automatically direct messaging to clinical resources based on role and their availability in real-time as well as manage escalation of messaging based on predefined service level rules
• Facilitate the day to day management and improvement of services while reducing costs associated with inefficient communication in the clinical environment.
Our HHT will review information requested from SM platform vendors in Year 1 to select a platform that best addresses the needs of our members, including provincial assets available for use by Ontario Health Teams (e.g. ONE Mail).
(3) eReferrals and eConsults

In Year 1, our HHT will work to identify barriers and promote uptake of eReferral and eConsults among member organizations to enhance how providers communicate to support transitions in care. Both platforms have improved patient experiences including reducing wait times and inappropriate referrals. Through planning discussions, our HHT has already identified the following barriers to uptake of eReferral and eConsult among our member organizations, these include:

• Costs for specialists to use platforms
• Lack of contextual information
• Consent and privacy concerns

Our HHT will continue to identify and define barriers and mitigation strategies to promote uptake. As part of our strategy in Year 1, our HHT will:

• Survey all member organizations to determine barriers to uptake of eConsult and eReferral for themselves and their stakeholders (clinicians, partner organizations);
• Collectively assess tools identified through a recent Request for Information process led by SJHH (including provincial active requirements Ocean, Novari, Strata) to select an eReferral and eConsult platform that works best for all member organizations.
• Work with the Ministry and our member organizations and stakeholder to address barriers to uptake of these platforms.

(4) Client Health and Related Information System (CHRIS)

We will continue to use the CHRIS Home and Community Care platform to support the delivery of home and community care services, as well as coordinate other health services including long-term care placements and referral to community support services within our HHT.

2.4 Digitally Enabled Quality Improvement

Describe how the members of your team currently use digital health tools and information to drive quality and performance improvement. How will your team build off this experience and capability so that it exists at the team-level?

Max word count: 500

Digital Health Tools

As detailed in Appendix B, Table B1, many of our member organizations use a variety of digital health tools to support
patients and drive quality and performance improvement. One of our biggest assets for driving improvement across teams is IDS.

Integrated Decision Support Business Intelligence Solution (IDS)

IDS is a multi-organization, cost shared, patient level data repository and business intelligence tool that offers the ability to track an individual through the continuum of care. Through IDS, currently 10 of our member organizations can access information on individuals across acute, homecare, primary, and community care sectors, including:
- Acute Inpatient, emergency department, day surgery and medical day care
- Inpatient rehabilitation, acute mental health, and complex continuing care
- Community Health Centres (including Aboriginal and French Language)
- McMaster Family Health Team (36 primary care physicians/39,372 patients)
- Homecare (CHRIS – Client Health and Related Information System) & InterRAIHC
- Hospital case costing and OHRS trial balance financials and statistics
- 2016 Census Data and health equity measures (Ontario Marginalization Index)

IDS serves as an analytical solution that is used to support ongoing planning, population health management, performance, outcome measures, and quality improvement. Through IDS, patient health information, costs, and socio demographic census data are available in one place, including indicators we will use to measure performance and drive quality for our HHT. Ministry and OHT indicators for HHT’s cohorts within its attributed population will be monitored in a timely manner with drill down ability to the record level for analysis and targeted interventions, as well as improved patient flow, wait times, and ALC rates by evaluating the integrated data to ensure streamlined access is occurring. Furthermore, to build on the success of IDS, in Year 1 our team plans to expand IDS to collect data from other care areas involved in an individual’s integrated care pathway. Increasing available data from other sectors will strengthen IDS’s ability to pool information from an individual’s integrated care pathway and help HHT better plan integrated care delivery, and understand population health needs and cost drivers, population segmentation and subsequently drive performance and quality improvement. Year 1 Initiatives include:
- Uploading EMS data to IDS;
- Piloting select community mental health organizations who are members of the HHT and scaling the approach to others through to maturity; and
- Expanding primary care data intake to additional providers within our HHT area (e.g. Hamilton FHT).
As we onboard Year 1 target population through integrated care pathways, IDS will continue to drive evidence based collaboration at patient and population health levels. Improved ability to monitor, track, analyze, and evaluate quality improvement and intervention level initiatives (pre and post) in many areas, such as multiple chronic conditions, mental health and addictions, frequent utilization, high cost occurrences, geographical areas of disadvantaged health equity status, etc., as well as predictive analytics using risk scores (Chalson, LACE, HARP, DIVERT) for those who may be in need of early intervention in our Year 1 target populations and general population.

2.5 Other digital health plans
Please describe any additional information on digital health plans that are not captured in the previous sections.

Max word count: 500
As demonstrated above, we have extensive experience with Digital Solutions that can be operationalized and scaled to Maturity and are committed to working with the Ministry.

In addition to the Digital Health plans outlined through Appendix B of our application our HHT is committed to the following guiding principles as we expand and scale our digital health capabilities through to Maturity:

(1) As a HHT, we make a commitment to each other to make all technology procurement decisions going forward only after explicit and meaningful consultation with HHT partners, and agree that any decisions that impact other partners or that will risk further digital health fragmentation from the lens of patients will be made only with consensus from relevant HHT partners.

(2) All HHT partners agree to enable patients to access all health information in their record, including notes (the latter potentially prospective to find the balance between benefit and potential harm while considering privacy concerns and amount/appropriateness of information shared).

(3) All HHT partners agree it is a patient’s right to access care virtually when the option is available within the organization (e.g. not available based on provider preference), and also have the right to choose non-virtual options if preferred.

(4) The HHT seeks to enable citizen activation in their health, and in supporting the health of others, outside of direct
engagement as a patient with an HHT partner for health or social services.

(5) Larger organizations will provide support to HHT solo providers or smaller organizations to assist with uptake of digital tools between Year 1 and maturity.

B.3  Who is the single point of contact for digital health on your team?
Please identify a single point of contact who will be the responsible for leading the implementation of digital health activities for your team.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Jeff Wingard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title &amp; Organization:</td>
<td>Project Director, Hamilton Health Team</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:jeff.wingard@hamiltonhealthteam.ca">jeff.wingard@hamiltonhealthteam.ca</a></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>NAME OF ORGANIZATION</td>
<td>TYPE OF ORGANIZATION</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>AbleLiving (Thrive Group)</td>
<td>COMMUNITY SUPPORT SERVICES</td>
</tr>
<tr>
<td>Alzheimer Society of Brant, Haldimand Norfolk, Hamilton Halton</td>
<td>COMMUNITY SUPPORT SERVICES</td>
</tr>
<tr>
<td>Canadian Mental Health Association - Hamilton Branch</td>
<td>MENTAL HEALTH AND ADDICTION ORGANIZATIONS</td>
</tr>
<tr>
<td>City of Hamilton</td>
<td>MUNICIPALITY</td>
</tr>
<tr>
<td>Good Shepherd Centres</td>
<td>COMMUNITY SUPPORT SERVICES</td>
</tr>
<tr>
<td>Hamilton Family Health Team</td>
<td>OTHER, PLEASE SPECIFY Family Health Team</td>
</tr>
<tr>
<td>Hamilton Health Sciences Corp.</td>
<td>HOSPITALS</td>
</tr>
<tr>
<td>Ildewyld Manor (Thrive Group)</td>
<td>LONG-TERM CARE HOMES</td>
</tr>
<tr>
<td>Indwell</td>
<td>COMMUNITY SUPPORT SERVICES</td>
</tr>
<tr>
<td>Lynwood Charlton Centre</td>
<td>COMMUNITY SUPPORT SERVICES</td>
</tr>
<tr>
<td>McMaster Family Health Team</td>
<td>OTHER, PLEASE SPECIFY Family Health Team</td>
</tr>
<tr>
<td>McMaster University</td>
<td>OTHER, PLEASE SPECIFY University</td>
</tr>
<tr>
<td>SE Health</td>
<td>HOME CARE SERVICE PROVIDER ORGANIZATION</td>
</tr>
<tr>
<td>St. Joseph’s Healthcare Hamilton (St. Joseph’s Health System)</td>
<td>HOSPITALS</td>
</tr>
<tr>
<td>St. Joseph’s Homecare (St. Joseph’s Health System)</td>
<td>HOME CARE SERVICE PROVIDER ORGANIZATION</td>
</tr>
<tr>
<td>St. Joseph’s Villa (Dundas) (St. Joseph’s Health System)</td>
<td>LONG-TERM CARE HOMES</td>
</tr>
<tr>
<td>St. Peters Residence (Thrive Group)</td>
<td>LONG-TERM CARE HOMES</td>
</tr>
<tr>
<td>Wayside House of Hamilton</td>
<td>COMMUNITY HEALTH CENTRES</td>
</tr>
<tr>
<td>Wesley Urban Ministries</td>
<td>COMMUNITY HEALTH CENTRES</td>
</tr>
<tr>
<td>NAME OF GROUP</td>
<td>PHYSICIAN NAME (Last name, First name)</td>
</tr>
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<td>-------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Medical Advisory Committee – Hamilton Health Sciences</td>
<td>Hospital (but membership also includes Primary Care)</td>
</tr>
<tr>
<td>Medical Advisory Committee – St. Joseph’s Healthcare</td>
<td>Hospital (but membership also includes Primary Care)</td>
</tr>
<tr>
<td>NAME OF NON-MEMBER ORGANIZATION</td>
<td>TYPE OF ORGANIZATION</td>
</tr>
<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td>Alternatives for Youth</td>
<td>Youth substance abuse support and counselling. Service coordination to be offered on-site.</td>
</tr>
<tr>
<td>Centre de santé communautaire Hamilton Niagara</td>
<td>Community Health Centre for Francophones; Primary care, counselling, allied health, and settlement</td>
</tr>
<tr>
<td>Compass Community Health Centre</td>
<td>Community Health Centre; Primary care, counselling, and allied health professionals</td>
</tr>
<tr>
<td>De Dwa Da Dehs Nye&gt;s Aboriginal Health Centre</td>
<td>Aboriginal Health Centre providing a variety of health care services, Health Promotion, Advocacy Services, Children’s Programs, Mental Health Programming, Traditional Healing</td>
</tr>
<tr>
<td>Dr. Bob Kemp Hospice</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>Hamilton Niagara Haldimand Brant Local Health Integration Network</td>
<td>Crown agency that currently plans, integrates and funds local health care as well as deliver and coordinate home and community care</td>
</tr>
<tr>
<td>Hamilton Wentworth Catholic District School Board</td>
<td>Education – Social Work division. Work with Secretariat for Early ID and re-aligning family supports</td>
</tr>
<tr>
<td>Hamilton Wentworth District School Board</td>
<td>Education – Social Work division. Work with Secretariat for Early ID and re-aligning family supports</td>
</tr>
<tr>
<td>Ontario Telemedicine Network</td>
<td>Provincial Digital Health Provider/Virtual Care</td>
</tr>
</tbody>
</table>