



Hamilton

INFORMATION REPORT

TO: Mayor and Members Board of Health	WARD(S) AFFECTED: CITY WIDE
COMMITTEE DATE: April 22, 2013	
SUBJECT/REPORT NO: Hamilton Central Health Link (BOH13016) (City Wide)	
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SIGNATURE:	

Council Direction:

Not Applicable

Information:

Background

On December 6, 2012, the Ministry of Health and Long-Term Care (MOHLTC), through the Local Health Integrated Network (LHIN), introduced Health Links, a new model where all providers in a community, including primary care, hospital, long-term care and community care are charged with coordinating plans at the patient level. With improved coordination and information sharing, patients should receive faster care, spend less time waiting for services and be supported by a team of health care providers at all levels of the health care system.

Each Health Links is accountable for system-level metrics established by the province. The initial focus will be on the high users of in-patient hospital and emergency department services, as the MOHLTC notes that patients with the greatest health care needs make up five per cent of Ontario's population but use services that account for approximately two-thirds of Ontario's health care dollars. This level of care is not sustainable, nor does it meet their needs.

OUR Vision: To be the best place in Canada to raise a child, promote innovation, engage citizens and provide diverse economic opportunities.

OUR Mission: WE provide quality public service that contribute to a healthy, safe and prosperous community, in a sustainable manner.

OUR Values: Accountability, Cost Consciousness, Equity, Excellence, Honesty, Innovation, Leadership, Respect and Teamwork

MOHLTC invited proposals from communities to be selected as one of 19 Early Adopters for Health Links. Over time, the Health Links model will be expanded across Ontario. By the end of 2013, the Hamilton-Niagara-Haldimand-Norfolk LHIN (HNHB LHIN) will have established a total of 12 Health Links. To be selected as an Early Adopter for Health Links, communities had to meet the following short-term Mandatory Requirements within the first year of operations:

- Must be focused on, or prepared to focus on, a defined region with a minimum population of 50,000, organized around natural health service utilization patterns.
- Must include health care providers/organizations involved in the care of the high use/high need population cohort, which at a minimum includes hospital, Specialists, Community Care Access Centre (CCAC) and primary care.
- Member providers must already show a high degree of collaboration and must be willing to sign written agreements formalizing their participation in the Health Link.
- Member providers need to have the ability to identify and track the high use/high needs population cohort (some assistance can be provided).
- Collaborating providers include minimum of 65% of primary care providers in the region.
- An identified and accepted Lead Organization in good standing as it relates to accountability and governance.

Hamilton Central Health Link (HCHL)

On November 21, 2012, the HNHB LHIN invited key community and health care stakeholders to discuss the opportunity to submit a proposal to establish an Early Adopter Health Link in the Central Hamilton area. Dr. David Price, Professor and Chair of the Department of Family Medicine at McMaster University and Chief of Family Medicine at Hamilton Health Sciences is the executive lead for this initiative. He is supported by a team from the Department of Family Medicine to ensure the development, administration, implementation and evaluation of the HCHL plan. Based on our initial proposal, HCHL was chosen as one of 19 early adopters across Ontario.

Each Health Link was required to submit a business plan by February 18, 2013 to the MOHLTC and their local LHIN to show how it will achieve short and long-term goals. The MOHLTC and the local LHIN will provide assistance to develop and implement this plan, as will other key partners like Health Quality Ontario and eHealth Ontario.

This report to the Board of Health outlines some of the key elements in the HCHL Business Plan. For more detailed information, the HCHL Business plan is included in

Appendix A. Appendix B includes the MOHLTC feedback to the HCHL Business plan and the HCHL response to the feedback.

HCHL Partner Organizations

Twenty-five organizations in Hamilton have committed to the HCHL model. These organizations represent a broad sector of services to residents, including health care, community, cultural and housing services.

Mission and Aim

MOHLTC has established the mission and aim of Health Links and HCHL has adapted this mission to fit with our local situation:

Mission: To transform the health system to maximize the health and health care experience of people in our region.

Primary Aim (for the first phase): Decrease hospital admission and emergency department (ED) visits among the top 5% cohort in this region.

Philosophy

Members of the HCHL have agreed to the following statement as a guiding principle to all initiatives that are developed from the Health Links model.

- The quality of provider-person and provider-provider relationships determines the quality of the health care experience and its impact.

Assumptions of the HCHL Model

Members of the HCHL have agreed to the assumptions that describe the current situation in Hamilton.

- That a person who makes frequent access of health and social services is likely experiencing some degree of social, psychological or physical instability.
- That this person “touches” all organizations and that all sectors provide many services and programs designed to cater to this person, and that adding new programs and services may not help.

- That many services and programs are already making a significant difference in a person's health and the experience of health care.
- That some programs and services are having relatively small impact, or possibly making the situation worse inadvertently.
- That there are proven approaches to improving social determinants of health (education, income, housing and others) that are likely to have a greater impact on health and experience of care than will changes to health services.
- That all sectors hold a piece of the solution, and that no sector holds the whole solution.
- That improvement will be demonstrated when there is greater collaboration among all sectors that serve people.

Region and Catchment Area

The HCHL extends from Highway 403 to Nash Road and from Lake Ontario to the escarpment. There are approximately 180 family physicians with clinic addresses in this area, 2 major tertiary care teaching hospitals with emergency departments, and most of the social service, mental health and addiction agencies in the city are located in this region, along with a concentration of paramedic service resources at any given time.

Population Profile

Several data sources from Hamilton hospitals and the HNHB LHIN have provided the following information about the population that the HCHL will aim to serve in the first phase of Health Links.

- The HCHL area includes 149,037 (11%) of the people in the HNHB LHIN (29% of people in the City of Hamilton), and the highest utilizers of health services.
- The high user cohort for HCHL was comprised of 320 individuals that accounted for 1,388 acute hospital discharges and 2,718 Emergency Department/Urgent Care Centre (ED/UCC) visits in 2011/12.
- More than 57% of the 320 individuals reported living in the 3 postal codes L8H, L8K, L8L.
- Half of the cohort was over age 65.

What HCHL commits to accomplish in the first yearInvent the Learning Circle

- The Learning Circle uses a learning and problem-solving process that will drive changes in how direct care for specific individuals is delivered, as well as changes in systems and policy. The Learning Circle will be facilitated by a clinician with expertise in organizational change and relationship centred care and administration.

Begin with study and intervention for the Top 5% Cohort

- The focus will be on the approximately 300 individuals who make up the top 5% for use of both inpatient and emergency hospital services. These individuals will help us to understand the factors that bring about high hospital use.

Agree upon and begin to use a standardized, comprehensive, person-centred care planning process

- The steps in this process will be to understand how care planning and case management can have its greatest impact and where there are gaps. This activity will develop a common strategy for case management in this city. The strategy will be tested and evaluated using quality improvement methods.

Introduce a robust patient engagement process

- Develop a process to be guided by the direct involvement and voice of the person who needs our services. This will progress over time to direct client involvement in all levels of the work.

Carry out quality improvement for current targeted services

- There are many programs and services that explicitly or implicitly include the aim of reducing hospital utilization. These services will be reviewed for their function, quality, impact and value to the community.

Enact change in systems and policy

- System and policy factors at levels of administration and governance could help or hinder the aim of Health Links. One of the areas identified for improvement is the access to point-of-care clinical data that will serve patients and health and social service providers better. Traditionally, health and social information is kept in separate data systems associated with institutions or clinics.

Evaluation Activities

Members from the Department of Family Medicine/McMaster Family Health Team and the HNHB LHIN will be responsible for overall planning, implementation and evaluation of the HCHL activities.

- System level economic evaluation will be conducted to determine if costs have been reduced for the top 5% of acute hospital discharges (7,235) and the top 5% of ED/UCC visits (43,476).
- Outcome mapping will document and measure social transformation, such as changes in behaviour, relationships, activities and attitudes.

City of Hamilton Participation

The City of Hamilton has a strong history of working with residents, community organizations and other institutions to ensure coordinate services. The Health Links model fits very well with the City of Hamilton's mission to provide quality public services that contribute to a healthy, safe and prosperous community, in a sustainable manner. The lead programs contributing to the HCHL plan include Public Health Services (PHS) Mental Health & Street Outreach, the Neighbourhood Strategy and Hamilton Paramedic Services. It is important to note that additional links with City services (e.g. Housing) will be made as the Health Links work unfolds.

Public Health Services, Mental Health & Street Outreach (MHSO)

- MHSO delivers an integrated model of service designed on a unique model that brings together service providers and their particular expertise to create a team that can meet the diverse needs of people. The MHSO provides long term case management and street outreach services to individuals over the age of 16 who are living with a serious and persistent mental illness and may be homeless. MHSO and other community partners have established a central point of intake (INTÂC) that ensures that individuals quickly receive the help that they need. MHSO also works closely with physicians and other services to support individuals to be as healthy as possible. MHSO is well positioned to support the development of the HCHL model in Hamilton.

Neighbourhood Development Strategy

- The City of Hamilton's Neighbourhood Development Strategy is focused on helping neighbourhoods to be great places to live, work, play and learn. Through research on the social determinants of health, evidence demonstrates that health status is affected by social determinants of health that include as income, housing, discrimination and education. Through the Neighbourhood Development Strategy,

the City of Hamilton is working with community partners, neighbourhood groups and residents to develop action plans to build healthier communities. Several neighbourhoods within the HCHL catchment area have developed Neighbourhood Action Plans and are well-positioned to provide another perspective to the HCHL.

Hamilton Paramedic Service

- Hamilton Paramedic Service developed the Community Referrals Emergency Medical Services (CREMS) in September 2010 as a solution for the increasing demands for service, lengthy offload delays at Emergency Departments and rising system costs. A significant goal of the CREMS pilot project was to demonstrate that patient referrals by paramedics to supportive community-based care could positively impact the reliance of these patients on paramedic services and Emergency Departments utilization for primary care. CREMS is a neighbourhood/community focused approach to assist patients in finding the most appropriate and relevant service. Hamilton Paramedic Service will be an important contributor to the HCHL business plan.

HCHL Advisory Board

The Advisory Board includes the Ministry mandated partners (hospitals, primary care and CCAC) and other important partners (e.g. City of Hamilton). City of Hamilton participants include Dr. Elizabeth Richardson, Medical Officer of Health and Paul Johnson, Director Neighbourhood Development Strategies. The members of this board are responsible to ensure the commitment of their teams to the HCHL, provide input to the initiatives and provide agreement on the initiatives of the HCHL. This board will meet bi-annually face-to-face.

Next Steps

PHS continues to actively promote collaboration between all providers in the City of Hamilton, including primary care, hospital, long-term care and community care. In order to fully support the new HCHL, the City has invested in a new Acting Director position to work closely with HCHL to facilitate alignment with City of Hamilton services, including PHS, the Neighbourhood Development Strategy, and other relevant services.

The HCHL Newsletter (Appendix C) provides recent updates and communication about the implementation to date. PHS will provide these updates to the Board of Health to keep them informed of project status and achievements.

Hamilton Central Health Link

Business Plan

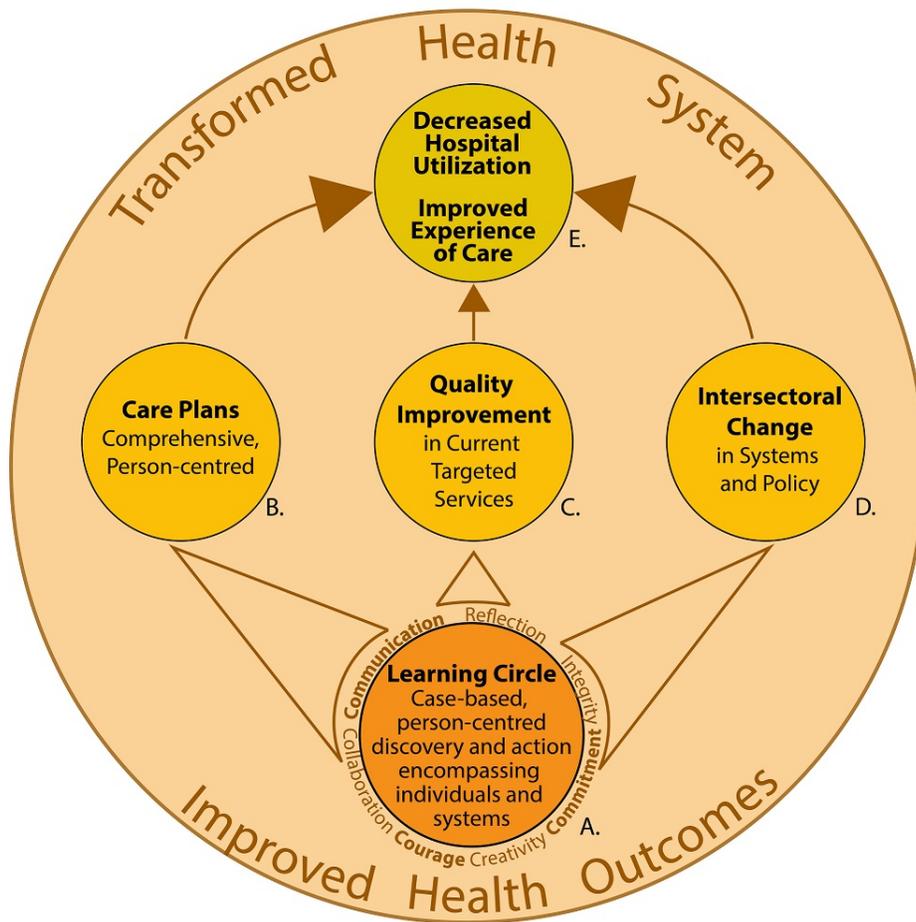


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Executive Summary

The early stages of the launch of the Hamilton Central Health Link (HCHL) initiative is another example of how the community is working together to build a strong, healthy city. It has been clear from the beginning that our partners in the health sector are committed to this initiative. It is also clear that all of those involved understand that improving health outcomes for residents of Hamilton requires the skills and resources of a broad array of partners including the Municipality and community-based service providers. This holistic approach is very much in keeping with the City's Neighbourhood Development Strategy, which is focused on improving the health, economic and social outcomes of residents in many of the neighbourhoods included in the HCHL initiative. We look forward to working with the HCHL "team" and discussing new ways to better address the health needs of those in our community.

Paul Johnson - Director, Neighbourhood Development Strategies - City of Hamilton, member of the HCHL Advisory Board, and active participant in developing this business plan

This business plan is the product of a large and eager coalition of twenty-six organizations that serve our population, demonstrating their creativity, cooperation, courage and investment as committed partners in the Hamilton Central Health Link (HCHL).

Among the diverse urban population of 150,000 living in HCHL, socioeconomic status is lower than average. There are 320 who are in the top 5% cohort for both hospital admissions and emergency department (ED) visits, with half over age 65, almost half admitted to CCAC prior to hospital, more than half with ED visits between 4 PM and 8 AM, half discharged home without specific supports, and most common reasons for presentation being chronic lung disease, heart failure and mental health.

Our mission and aim have essentially been "delivered" to us by the Ministry of Health and Long-term Care, and we have adapted those somewhat to fit with our local situation and goals.

The mission of HCHL is: *Transform the health system to maximize the health and health care experience of people in our region.*

Our primary aim is: *Decrease hospital admission and emergency department (ED) visits among the top 5% cohort in this region.*

Our philosophy is that the quality of provider-person and provider-provider relationships is what determines the quality of the health care experience and its impact. Relationships will be improved by embracing all forms of success and failure as essential elements of the learning process, through conversations that invite thoughtful risk and avoid simplistic explanation.

Our Assumptions that will guide our work:

- That a person who makes frequent access of health and social services is likely to be experiencing some degree of social, psychological or physical instability
- That this person "touches" all of our organizations, that we (all sectors) provide many services and programs designed to cater to this person, and that adding new programs and services may not help
- That many of our services and programs are already making a significant difference in a person's health and the experience of health care
- That some of our programs and services are having relatively small impact, or possibly making the situation worse inadvertently

- That there are proven approaches to improving social determinants of health (education, income, housing and others) that are likely to have a greater impact on health and experience of care than will changes to health services.
- That all sectors hold a piece of the solution, and that none of us holds the whole solution
- That the only way we will improve what we are doing is to collate our experience and wisdom, and make collective decisions and strategies that ultimately will serve the person and all of us better

What HCHL commits to accomplish in our first year of operation:

Not deliver direct service programs. There is already a large resource base and there are many effective initiatives being delivered. There is room to achieve better impact from all of our services and programs if we improve and re-align what is already being delivered.

Invent the 'Learning Circle', a novel forum for carrying out inter-sectoral quality improvement work. Our core methodology is a novel learning and problem-solving process that will drive changes in how direct care for specific individuals is delivered, as well as changes in systems and policy. Our project will need to draw upon the experience of people who work within health care and community agencies, the experience of people who need and/or receive service and care, and quantitative data on service utilization.

Begin with study and intervention for the Top 5% Cohort: For the first year of operation, we will make a focused effort with approximately 300 individuals who make up the top 5% for use of both inpatient and emergency hospital services. These individuals will help us to understand the factors that bring about high hospital use. We will also focus our efforts on improving the health care experience for these individuals, by implementing the novel care planning process that our coalition develops. We will simultaneously develop a procedure to screen people at risk of becoming high users of the health system.

Introduce a robust patient engagement process: A social animator/narrator in residence will gather patient/client/caregiver stories and deliver those in a variety of effective formats to places where they are needed to inform problem-solving conversations. We will use this starting point to become increasingly guided at every level of our work by the direct involvement and voice of the person who needs our services. This will progress over time to direct client involvement in all levels of our work.

Agree upon and begin to use a standardized, comprehensive, person-centred care planning process: We will draw upon the wealth of experience and resource that currently exists in many organizations including case managers, system navigators, care connectors and others. We will study, discuss and deliberate in order to arrive at the key elements that will render care planning to have highest impact among those who use health services most.

Carry out quality improvement for current targeted services: There are many programs and services already being implemented in this community that explicitly or implicitly include the aim of reducing hospital utilization. We have developed an initial inventory of these, and will maintain this inventory to be able to constantly review their function, quality, impact and value to the community overall.

Enact inter-sectoral change in systems and policy: We predict that our Learning Circle activities will help to illuminate where system and policy factors are helping and where they are hindering our attainment of the aim. Where these become clear, the Partners will determine how to advocate for change in these systems and policies at relevant levels of administration and governance. Our partners have already identified an area in need of improvement, and thus in the first year we will improve point-of-care clinical data access through development of clinical data sharing hub that will serve patients and health and social service providers better, drawing upon all of the current IT assets in the LHIN.

1.0 Health Link Profile

1.1 Key Contacts

LHIN:	Hamilton Niagara Haldimand Brant LHIN
LHIN Health Link Contact:	Donna Cripps
Phone:	(905) 945 - 4930 ext.
Email:	Donna.Cripps@LHINS.ON.CA

Health Link Name ¹ :	Hamilton Central Health Link (HCHL)
Lead Organization:	McMaster Department of Family Medicine/McMaster Family Health Team
Primary Health Link Contact:	David Price
Mailing Address:	Department of Family of Medicine McMaster Innovation Park (MIP) 175 Longwood Road South, Suite 201A Hamilton, Ontario L8P 0A1
Phone:	(905) 525 - 9140 ext.21253
Email:	priced@mcmaster.ca

1.2 Collaborating Partners

This business plan is the product of a large and eager coalition of twenty-four organizations that serve our population, demonstrating their creativity, cooperation, courage and investment as committed partners in the Hamilton Central Health Link (HCHL).

This group began to form in December 2012, has met on two occasions since then in its entirety and on many occasions in smaller formats, to deliberate over how the work of HCHL should unfold. The HNHB LHIN has been intimately and supportively involved in all facets of plan development thus far. Partners are listed below, along with the statements of cooperation they were invited to endorse. All partners have reviewed a draft of this business plan, have provided feedback for revision and improvement, and have requested to be able to sign their names in support of the proposed plan. They represent most sectors that are relevant to people with high health service utilization.

The organizations/agencies were asked the following two questions at the first partners' meeting, and all 25 responded "yes" to both (Table 1). In addition, see section 4.1 for a description of programs and contributions these organizations are committing to this work, and Appendix C for a list of the organizations and people involved in HCHL.

1. *Do you agree to be a cooperating partner of the HCHL?* You are a cooperating partner if you see this work as valuable to your organization and to the people you aim to serve. You should choose this category if you are committed to the work, and will aim to orient your staff, management and boards to be conscious of and responsive to this work. Your commitment will need to include a willingness to study data and information related to people who make frequent hospital visits; to help to develop person-centred solutions; to reflect on your organization's impact on this issue; to work toward changes in your organization that could enhance your impact; and, to work with other HCHL partners to advocate for changes at higher levels where appropriate. McMaster DFM/FHT, supported by the HNHB LHIN, will be your resource for this process.

2. *Do you request an opportunity to endorse the Business Plan development?* If your organization agrees to be a cooperating partner, and in addition you wish to have an opportunity to express your support of the details in the business plan, indicate that here. You will have an opportunity to review and provide feedback on a draft of the business plan between February 1 and 7, and to attend a final revisions meeting on Monday Feb 11 at a time to be determined. If you wish to have this opportunity, indicate this by checking the box and sending in this form by January 25. You will then be included in the review process, and will be invited to sign the business plan by February 17.

Table 1: Organizations/Agencies Responses

<i>Organizations/Agencies</i>	<i>Cooperating Partner</i>	<i>Endorse Business Plan</i>
Hamilton Health Sciences (HHS)	Yes	Yes
St. Joseph's Healthcare Hamilton (SJHC)	Yes	Yes
HNHB Community Care Access Centre	Yes	Yes
City of Hamilton including: Public Health Services (Mental Health and Street Outreach Services, Alcohol, Drug and Gambling Services), Neighbourhood Strategy (City Manager's Office), Community Services Dept (Paramedic Services, Housing and Homelessness)	Yes	Yes
AbleLiving Services Inc.	Yes	Yes
Alternatives for Youth	Yes	Yes
Brain Injury Services	Yes	Yes
Canadian Mental Health Association (CMHA), Hamilton Branch	Yes	Yes
Centre De Santé Communautaire Hamilton-Niagara	Yes	Yes
De dwa dehs nye's Aboriginal Health Centre	Yes	Yes
Good Shepherd	Yes	Yes
Hamilton Family Health Team	Yes	Yes

<i>Organizations/Agencies</i>	<i>Cooperating Partner</i>	<i>Endorse Business Plan</i>
Hamilton Program for Schizophrenia	Yes	Yes
Hamilton Urban Core Community Health Centre	Yes	Yes
North Hamilton Community Health Centre	Yes	Yes
Seniors Activation Maintenance (SAM) Program	Yes	Yes
Shelter Health Network	Yes	Yes
Southern Network of Specialized Care	Yes	Yes
The Hamilton Clinic	Yes	Yes
VON Canada – Ontario Branch	Yes	Yes
Wayside House of Hamilton	Yes	Yes
Wellbeings Pain Management and Dependency Clinic Inc.	Yes	Yes
Wesley Urban Ministries	Yes	Yes
YMCA of Hamilton/Burlington/Brantford	Yes	Yes
YWCA Hamilton	Yes	Yes

1.3 Health Link Population

Among the diverse urban population of 150,000 living in HCHL, socioeconomic status is lower than average. There are 320 who are in the top 5% cohort for both hospital admissions and ER visits, with half over age 65, almost half admitted to CCAC prior to hospital, more than half with ER visits between 4 PM and 8 AM, half discharged home without specific supports, and most common diagnoses COPD, heart failure and mental health.

1.3.1 Region and Catchment Area

The HCHL extends from Highway 403 to Nash Road and from Lake Ontario to the escarpment (Appendix B: Map of the HCHL). There are approximately 180 family physicians with clinic addresses in this area (unvalidated estimate), 2 major tertiary care teaching hospitals with emergency departments, and most of the social service, mental health and addiction agencies in the city are located in this region. The city is served by 2 large family health teams (McMaster FHT with 30 physicians and Hamilton FHT with 130 physicians) and 4 CHC's that provide service in this region.

From the current records of the CCAC, there are a total of 162 Physicians located within the catchment area (6 postal codes: L8H, L8K, L8L, L8N, L8P, and L8R). It is worthy to note that physicians whose offices are located outside this catchment area may in fact have patients who live within the HCHL catchment area. However for the purposes of this plan, any physician who has an office located outside the catchment area is this total.

Of the 162, 66 (41 %) Physicians' offices have an HNHB CCAC care coordinator assigned to work directly with the physicians' patients. A "care coordinator attachment" indicates an alignment of CCAC staff with the primary care physician/team which facilitates a closer working relationship on behalf of the patient. 96 Physicians' offices have no specific CCAC care coordinator attached (source: HNHB CCAC Physician Attachment Statistics). In the meantime the CCAC continues to assign the patients of the unattached physicians to the care coordinator who covers the geographic area where the patient lives. Those patients who require specialty care such as palliative care, short stay acute, children's health and renal care are assigned to specialty care coordinators who travel in wider geographic areas.

1.3.2 Ontarians within Hamilton Central Health Link

Population profile: The HCHL area includes 149,037 (11%) of the people in the HNHB LHIN, and the highest utilizers of health services. According to 2011 Census data 75% of HCHL residents include English as their mother tongue which is fewer residents than in the HNHB LHIN (81%) and more than the province (70%). Fewer residents in the HCHL (2%) and HNHB LHIN (2%) included French as their mother tongue than in the province (4%). More residents in HCHL had no knowledge of English or French (3%) than in the HNHB LHIN (1%) and province (2%). According to 2006 Census data 26% of residents were immigrants which is higher than in the HNHB LHIN but less than in the

province (28%) and 5% of the immigrants had arrived within 5 years which is more than in the HNHB LHIN (2%) and about the same as the province (5%). More residents in the HCHL were visible minorities (15%) than in the HNHB LHIN (9%) but less than in the province (23%). More residents self-identified as Aboriginal (3%) than in the HNHB LHIN (2%) and province (2%). In 2006 Census fewer people in the HNHB LHIN were in the labour force (62%) than those in the HNHB LHIN (66%) and province (67%) and the unemployment rate was higher (9%) than in the HNHB LHIN (6%) and the province (6%). In 2006 more residents in HCHL did not have a certificate, degree, or diploma (23%) than those in the HNHB LHIN (15%) and province (14%) and fewer people in the HCHL completed post-secondary education (49%) than those in the HNHB LHIN (58%) and province (61%). In addition, in 2006 more residents in the HCHL were living below the low-income cut-off (24%) than in HNHB LHIN (14%) and the province (15%).

Unplanned hospital admissions: This data is drawn from the Integrated Data System of HNHB LHIN, which includes an aggregated minimum data set from hospitals, CCAC and CHCs. The time period is April 2011 through March 2012. There were 7,235 residents of the HCHL area discharged from an acute care hospital in the HNHB LHIN during the fiscal year 2011/12 ('urgent/emergent' [i.e. unplanned] hospitalizations only). These people represented a total of 9,887 discharges during the year where they provided a residential address located within the Hamilton Central area. The number of discharges per person ranged from 1-24 unplanned acute care hospitalizations during 2011/12. The top 5% of acute care hospital users for people residing in this area was identified based on the number of discharges over the year. A cut off of 3 or more discharges per person was used to represent the top 5% of acute care hospital users in the Hamilton Central area (actually 7.4%).

Emergency department visits: There were 46,476 HCHL area residents who visited an emergency department or urgent care centre (ED/UCC) in the HNHB LHIN during the fiscal year 2011/12 (unscheduled visits only). These people represented a total of 84,132 discharges during the year where they provided a residential address located within the Hamilton Central area. The number of unscheduled visits per person ranged from 1-96 during 2011/12. The top 5% of ED/UCC users was identified based on the number of visits over the year, which includes persons who made a total of 5 or more visits during the year. The top 5% of ED/UCC users in the HCHL area accounted for 17,431 visits in 2011/12.

Combined hospital admissions and emergency department visits: Individuals from the top 5% of acute hospital discharges were then cross referenced to the top 5% ED/UCC visits to provide a cohort of individuals that are high users in both systems. The high user cohort for HCHL was comprised of 320 individuals that accounted for 1,388 acute hospital discharges and 2,718 ED/UCC visits in 2011/12. From this point forward the *high users* will refer to this group of 320. (Figure 1)

Here are the main characteristics of these 320 people. More than 57% of 320 patients reported living in the 3 postal codes L8H, L8K, L8L, and the range of high users per 10,000 population ranged from 18 to 27 in each of these communities. Half of the cohort was over age 65.

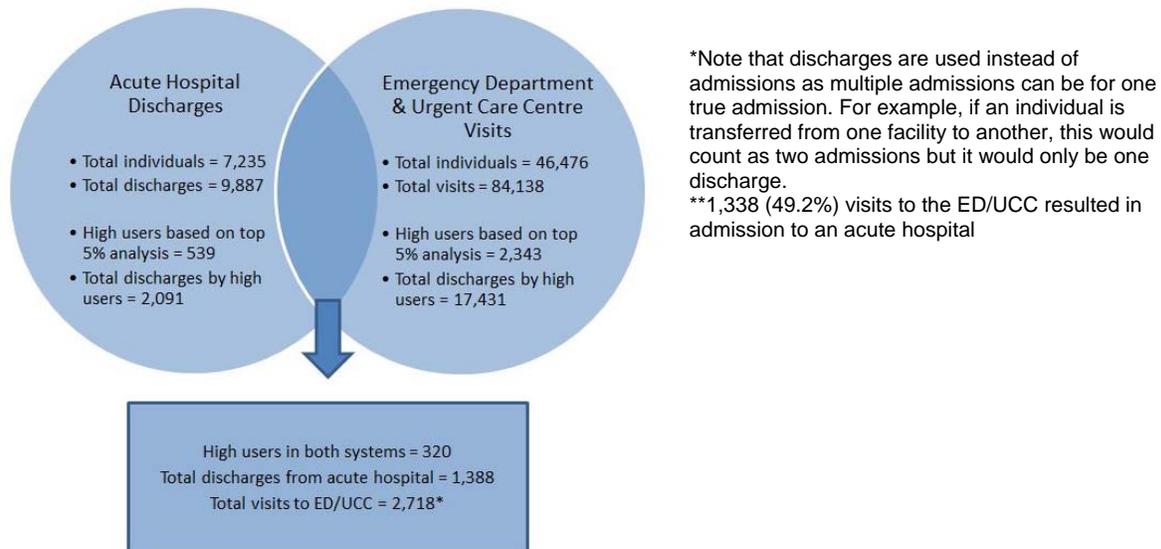
The 1388 discharges from hospital inpatient stay were characterized by: Disposition for 46 discharges (3%) was death (i.e. There are at most 274 individuals alive in this cohort and for 46 of them high hospital use was in their last months of life); 117 transfers to continuing care (8%), 413 discharges to some form of home setting with support services (30%), and 721 (52%) discharged home without supports. Among the discharges, 145 (10%) received any type of service at a Community Health Centre (CHC) at least once in the previous 3 years (not validated), and 648 discharges (47%) were active clients of Community Care Access Centre (CCAC) at the time of admission.

The reasons for hospitalization (admission) include: main diagnosis COPD for 15%, cardiac failure for 8%, urinary disorders 3%, and all others 2% or less.

Among the 2718 ED/UCC visits, characteristics were: 38% of discharges were from SJHC and 38% from HHS-General site; 45% discharged to an inpatient unit and 41% were discharged home; 56%

of visits to ED/UCC 4PM-8AM; 17% were non-urgent or semi urgent (CTAS 4,5), the rest were urgent to resuscitation; main diagnosis 10% chronic lung disease, 5% heart failure, 5% abdominal and pelvic pain, 5% mental health or substance abuse. In addition, 24% of the 320 patients had at least 1 visit since 2008 with mental health or addictions as the major reason for visit.

Figure 1. Defining the Population



2.0 Health Link Commitments

Our measures of success are the following:

1. All 320 in our top 5% cohort will have been reviewed and have formal and informal circle of care defined, care plans developed, and a circle of care engaged in implementation of that care plan. With those for whom care planning is deemed impossible, reasons for this will be well described.
2. Among the top 5% cohort, at least 20 will have been reviewed in depth at the Learning Circle and lessons learned about the care planning process and system/policy gaps and opportunities will have been documented and followed up as appropriate. Action and outcomes of this follow-up will be documented.
3. Among the top 5% cohort all who are not engaged with primary care will have problem-solving carried out in order to achieve this, and a system-level solution for improving access to primary care among this population in general will have been developed.
4. At least 1 high leverage policy change will have been achieved. All lessons and system/policy actions will be communicated broadly to all partners, LHIN and Ministry.
5. Among the top 5% cohort (and the general population) we will report quarterly on hospital admissions and ER visits, in order to demonstrate the decrease we anticipate.
6. We will have at least 20 patient stories of experience with health services and the health system made public within the HCHL network for the purpose of understanding the problem and illuminating solutions.
7. We will have at least 2 patient/caregiver units involved at an engagement and collaboration level with the HCHL process (in the process of planning and decision-making)
8. We will have in place a process for identifying people who are at risk of becoming high utilizers of health services and will be ready to implement this process to address high utilization at the earliest point.

9. We will be able to report that all of the partners have a sense that this work has moved forward and that their work with individuals who need health services most has become more clear and more effective.
10. We will understand what the requirements are for IPOC-IS and subject to confirmation of funding in a timely manner will substantially implement in year 1.

2.1 Overview of HCHL Activities

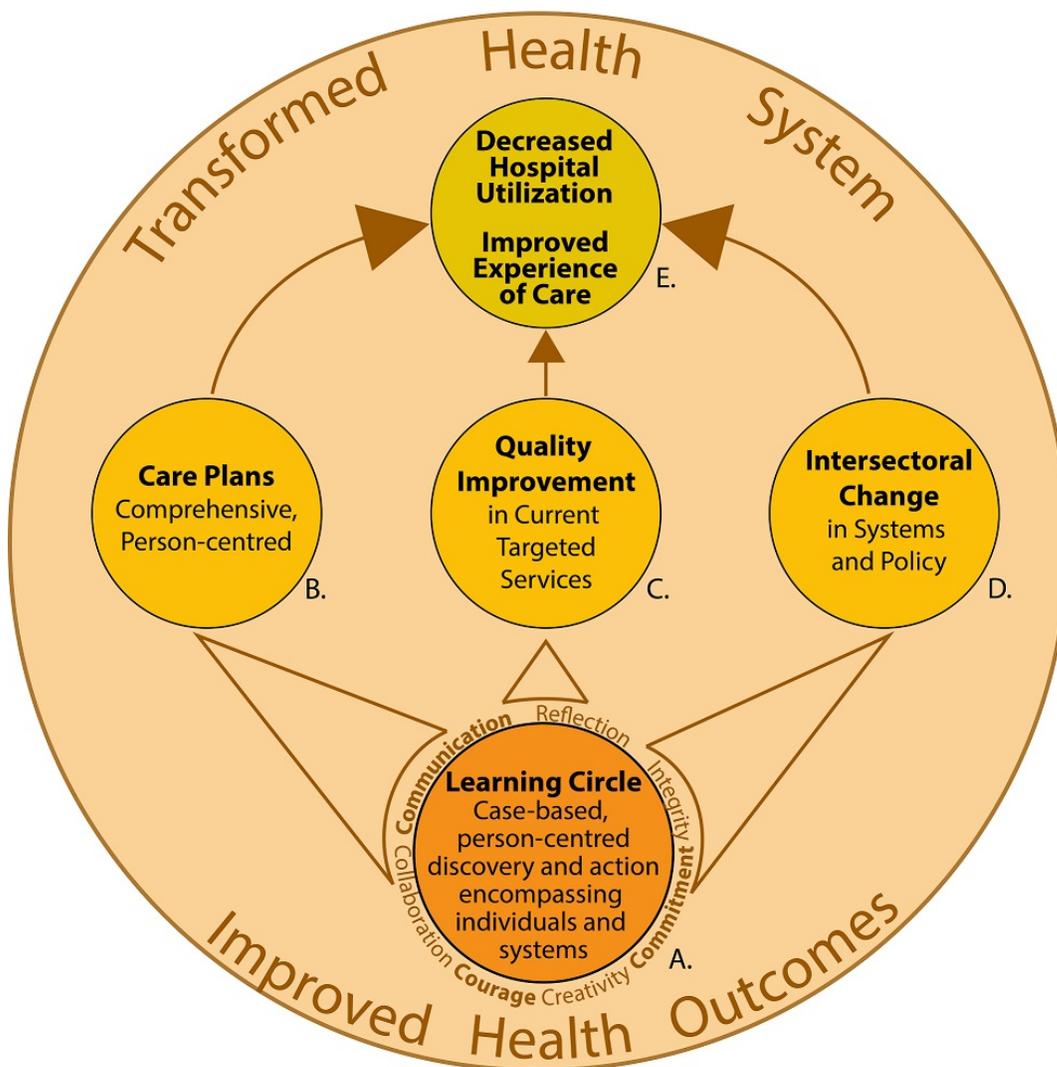
Transformation of the health system in our region will be powered by the core methodology of our novel 'Learning Circle', involving person-centred problem solving, engaging all relevant agencies and sectors, improving current services that target high utilization, developing a high impact individual care planning process, conducting small quality improvement experiments for innovation, and promoting broader system and policy changes at all levels. (Figure 2)

Our over-arching *aspiration* is to **transform the health system to maximize health and the health care experience of people in our region (large circle).**

Our primary *aim* that will focus our work is to **decrease hospital admission and ED visits among the top 5% cohort in this region (circle E).**

It is our impression that, in focusing our attention on this singular aim (which is encompassed in the Ministry's Results-Based Metrics 3 and 5, circle E below), we will inevitably have to work on several of the other metrics to achieve this aim, and in achieving this aim we will also have an impact on further required metrics. (Table 2) Other reasons for choosing to focus on this aim are the ease with which we can measure progress using the integrated data system and analysis framework already in place; several pilot projects targeting this aim that have already provided valuable learning; and a coalition of agencies already convened to deliberate around this topic (the Complex Care Systems Planning Table).

Figure 2. Transformation Plan



Our core methodology and engine for action and transformation is the Learning Circle (described in following section, see Figure 2 circle A). We expect the Learning Circle to have a direct impact on 3 primary outcomes: a comprehensive person-centred care planning process (circle B); quality improvement in current services that target the HCHL aims (circle C); and, system and policy changes to eliminate barriers and increase facilitators of effective and coordinated care (Circle D).

Table 2. HCHL Activities

Mission or Aspiration	Aims	Process	Measure/Indicator
<p>Transform the health system to maximize health and health care experience of people in our region.</p> <p><i>Also: Reduce the average cost of delivering health services to patients without compromising quality of health care.</i></p>	<p>PRIMARY AIM: <i>Decrease hospital admission and ED visits among the top 5% cohort in this region. (Results-based metrics 3,5)</i></p> <hr/> <p>SECONDARY AIMS that will be instrumental in achieving the primary aim: <i>Reduce the number of 30 day readmissions to hospital (Results-based metric 1)</i> <i>Reduce time from referral to home care visits (Results-based metric 4)</i> <i>Primary care follow-up within 7 days of discharge (Results-based metric 6)</i></p> <p>TERTIARY AIM that we will focus less on in year 1: <i>Achieve an ALC rate of 9% or less (Evaluation-based metric 2)</i></p>	<p>LEARNING CIRCLE METHODOLOGY will accomplish the following:</p> <ul style="list-style-type: none"> • Ensure the development of care plans for all compromised patients in the top 5% cohort (Operational Metric 2) • Increase the number of compromised patients and seniors in the top 5% cohort with regular and timely access to primary care (Operational Metric 1) • Quality improvement of current targeted service system/policy changes beginning with integrated clinical information systems through IT innovation 	<p>See Appendix A</p>

2.2 Description of Activities

2.2.1 Invent the Learning Circle (Circle A)

Our core methodology is a novel learning and problem-solving process that will drive changes in how direct care for specific individuals is delivered, as well as changes in systems and policy. Our project will need to draw upon the experience of people who work within health care and community agencies and the experience of people who need and/or receive service and care.

This experience can be taken up in many ways. One is through the systematic collection and scrutiny of quantitative data regarding utilization, diagnoses, and access. These metrics form an important but very incomplete picture of “experience”. The story of data is only as good as the procedures and algorithms for its collection and analysis. It is a useful starting point for generating hypotheses and measuring specific impacts of interventions. Numbers do not generate suggestions for change.

Another form of inquiry into experience is through qualitative methods. The most effective unit of qualitative inquiry is the story. By putting experience into a human context, a story has the power to evoke both analysis and imagination. Stories have the power to catalyze change. The giving and receiving of stories is also a way to build relationships and trust. Health care transformation would not be possible without the careful cultivation of stories. We will seek stories that reflect two particular perspectives: the experience of the person/caregiver, and the experience of the provider. This will be carried out by a social animator/narrator whose sole role will be to seek out, document

and disseminate the stories that will be the data for Learning Circle deliberations. (See section 3.0, Patient Engagement)

When used together, numbers and stories offer a powerful and potentially irresistible force for change. The Learning Circle creates the space for qualitative and quantitative data to be taken up in the service of transformation at both the individual and system level.

As the central engine of HCHL innovation, the Learning Circle will be convened on a frequent and regular basis to deeply explore relevant numbers and stories, generate solutions for change, and using a quality improvement framework model, track the failures and successes of our collective experiments. Standing members of the Learning Circle will include foundational HCHL partners from the hospital, primary care and the CCAC. Additional consultation will be sought from the HCHL partner agencies on a frequent ad hoc basis. The intent is to work towards an inclusive and broadly based process that encourages trans-sectoral learning and experimentation. The Learning Circle will be facilitated by a clinician with expertise in organizational change and relationship centred care and administration.

Patient/client/caregiver engagement within the Learning Circle is fundamental and will occur through story collection and curating, consultation with our patient engagement advisory group and, where feasible, direct involvement. (Section 3.0)

The start of the Learning Circle process will be the deep exploration of the qualitative and quantitative data available from the initial Top 5% cohort of identified clients. In working through these individual cases, we will also identify themes that transcend individuals and relate to needs at the system or policy level. The Learning Circle's mandate will be to move between the individual and agency/system level to generate and ultimately test possibilities for improvement in all domains. Once we have gained confidence on our processes, we will transition to electronic platforms that will support frequent, short meetings with participants from distributed sites. We are aiming for the capacity for frequent, nimble, brief meetings that allow for rapid response to identified issues.

To illustrate, here are few examples.

Ms. B is a member of our Intense Study Cohort of 320 people. A service provider has explored with Ms. B about her social, psychological and medical issues and how they relate to health and social service utilization. Information available from data systems and from interviewing Ms. B is brought to the table for discussion without personal identifiers to protect privacy. It becomes clear that the care plan developed by CCAC's case management process has offered a solution to address Ms. B's specific needs. However, her case highlights a system gap regarding care for isolated elders with anxiety and addiction issues.

The next Learning Circle meeting involves the core group as well as several representatives from outpatient addiction and mental health services. Ms. B's story is briefly told. A small scale experiment involving family physicians, addiction counsellors and the CCAC is devised. The group commits to reporting back to the Learning Circle within two months to share their findings regarding feasibility and impact of their project. The Social Animator meets with Mrs. B in three months' time to explore her experience of care.

The core values of the Learning Circle are indicated in Figure 3. We understand that a deep and thoughtful understanding of the issues are as important at this stage as a move towards solutions. We are committed to being mindful of the dangers of 'premature closure' – of trying to merely address the needs of an individual without understanding how one person's experience can teach us more about the vulnerability and opportunities of an imperfect and interconnected system.

2.2.2 Create Comprehensive Person-Centred Care Plans (Circle B)

Our region has within it many types of service coordinating roles: case managers, system navigators, care navigators and others. These are housed in a variety of organizations: hospitals, family health teams, community health centres, social service agencies, assisted living locations,

and many more. One person may receive service from several of these, and it is often not clear if one coordinator plays the primary role. There are many different philosophies, models and approaches being used, and a variety of different goals being achieved.

Our hypothesis is that excellent inter-sectoral care planning will be vital for many who frequently need health services, and that a “connector” role will need to be part of this. We will need to reach consensus about the most important elements required in care planning, who best to deliver those, and how best to resource that function. We will need to understand how best to make this function relevant to and driven by the person and their caregivers.

The CCAC has agreed to take a lead role in facilitating a process to draw on expertise both within and outside our community. CCAC has the largest case management resource in the city, and a great deal of experience with different models. It has particular expertise in working with people with chronic disease, the elderly and palliative patients. It has less expertise with mental health and addictions in this community. The steps in this process will be to understand through the Learning Circle how care planning and case management can have its greatest impact, where there are gaps, and to convene all relevant players to deliberate on a common strategy for case management in this city. The strategy will be tested and evaluated using quality improvement methods.

2.2.3 Quality Improvement for Current Targeted Services (Circle C)

There are many programs and services already being implemented in this community that explicitly or implicitly include the aim of reducing hospital utilization. We have developed an initial inventory of these, and will maintain this inventory to be able to constantly review their function, quality, impact and value to the community overall.

Our work together will be guided by a quality improvement framework, where the services that we provide will be studied, improved, monitored, and accountable to the entire HCHL coalition. Three forms of information will be the substrate that will fuel this deliberation: the patient/caregiver story, the provider story, and system utilization data. We will ask ourselves: *what is working and is ready for enhancement; what is not working and needs to be changed or re-aligned?*

Many organizations already have years of experience in programs and services that are geared to help people receive excellent care in the community and avoid unplanned hospital visits. These programs and services need to be catalogued, described, discussed and monitored for all to learn from and to aid in decisions about where energy could best be spent across sectors. There are also many new ideas for programs and services, and we expect more will emerge through this process. The actual work of HCHL will be structured around the following key QI elements.

STUDY FACTORS CONTRIBUTING TO THE PROBLEM—Much of our work will be to understand as deeply as possible what factors are contributing to high hospital utilization. This step needs to be as complete as possible before jumping into solution formation. Our “drill deep” study will consider patient/caregiver experience, provider experience, and system-level information.

CONSENSUS-BASED SOLUTIONS—Many potential solutions are already in place as processes, procedures, programs and services. These need to be reviewed. Novel solutions will be formulated for small and rapid tests of impact. The procedures and processes that are already in process, and those that are to be tested, will be clearly articulated until they can be agreed upon by all relevant partners.

MONITOR PROCESS IMPLEMENTATION—We will continually ask ourselves how well a process is *actually* being implemented, whether it is being delivered or carried out as planned, and if not, what needs to change to make this implementation more successful. Our work will be to reduce variation in the way a process is carried out and make implementation as consistent as possible.

MEASURE OUTCOMES—We will measure the indicators as outlined in Appendix A, and evaluate whether the impact of the process is adequate, or the process needs to be altered or eliminated.

START AGAIN—The above steps will be repeated rapidly in order to continue to monitor impact and improve until acceptable performance is reached.

2.2.4 Intersectoral change in Systems and Policy (Circle D)

We predict that our Learning Circle activities will help to illuminate where system and policy factors are helping and where they are hindering our attainment of the aim. Where these become clear, the Partners will determine how to advocate for change in these systems and policies at relevant levels of administration and governance.

Our partners have already identified an area in need of improvement, that being communication and sharing of relevant patient health information among an inter-sectoral care team in a manner tightly integrated with the patient and their personal support network. Accurate, comprehensive, timely and accessible data is a critical success factor influencing all aspects of the patient and provider experience, the health and system outcomes generated through those experiences, and our ability to assess the quality of those experiences and outcomes. To achieve this objective, improved alignment, greater integration and augmentation are required in information systems at the point of care and in the domain of health system coordination and analytics.



Figure 3

Point of Care Information Systems

Key to improving patient and provider experiences and the patient’s health journey at the point of care is enabling easy access to all information about the patient that captures their health status and the interplay of factors influencing that status. Traditionally, efforts have focused on integrating data about the patient held in disparate information systems associated with institutions or clinics at which a patient has received health services (e.g. hospital, CHC, CCAC, family physician, etc.). While vitally important, this data represents only one of several domains that influence health status. To truly capture health status and its determinants, the integrated information must also include the perspective of community social services with which the person is connected, and most importantly the perspective of the person and their support network.

Enabling seamless and secure communication between the patient and their circle of care, and between members within that circle of care, is another core requirement. In this context, the circle of care encompasses all those who from the patient’s perspective are supporting or influencing her/his health journey, be they health service providers, social service providers, family members and/or friends.

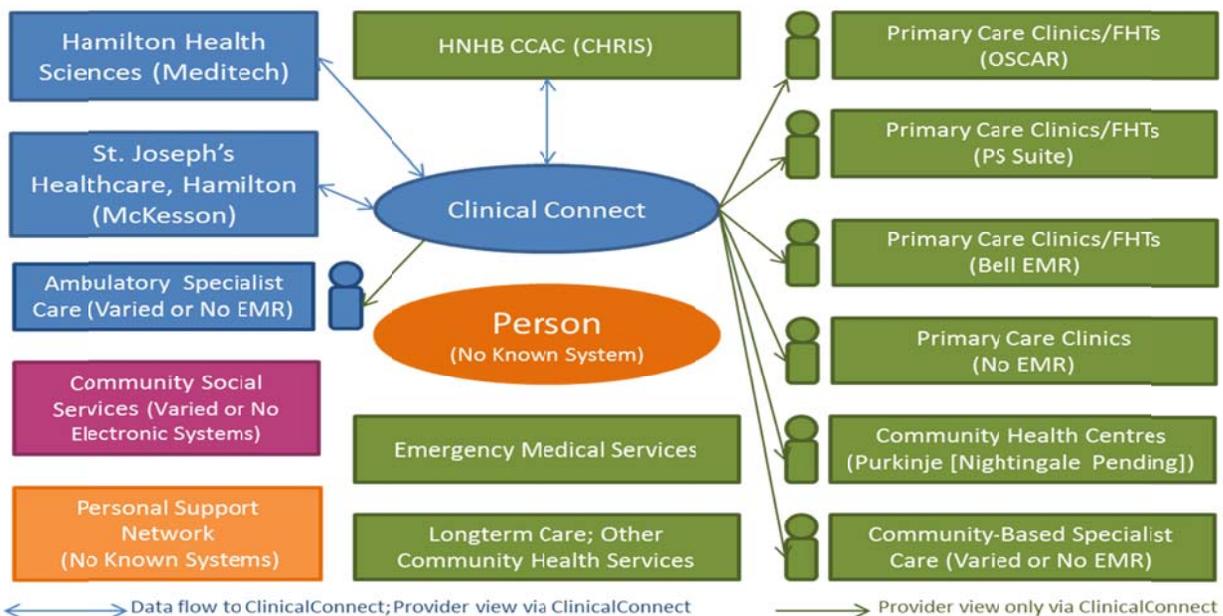
Finally, providing patients with access to resources and supportive tools targeting their unique needs and facilitating greater engagement in self-management must be an integral function of the integrated information system. This functionality extends the influence and impact of providers beyond the in-person encounter with the patient, and offers the patient and their support network the opportunity to take a more informed and active role in improving their own health.

Current State

The HCHL is privileged to be part of a LHIN and a community of health service providers committed to collaboration and innovation in the realm of health information systems. This, combined with eHealth Ontario/Ontario MD's support and encouragement of EMR adoption by primary care providers and specialists, has created a strong foundation on which to create the required, integrated point of care information system (see Figure 4: Current State).

Figure 4

Current State*



* Not intended as a detailed schematic of all existing connections but as high level conceptual diagram to illustrate the enhanced connectivity between core components as proposed for IPOC-IS.

Gap Analysis

The gap between current and desired state spans a continuum from relatively small to significant. While great strides have already been taken in integrating hospital systems and making hospital data available to providers through ClinicalConnect, **integration of data from health service providers in the community remains unrealized, and the inclusion of data from relevant social services or patients and their support network has to date been beyond the scope of any planning.**

To move the system toward desired state, the following enhancements/developments are required:

1. **Complete the integration of data between health service providers with existing electronic records:**
 - OSCAR - McMaster FHT; Shelter Health Network; Hamilton Public Health Services; McMaster Student Health Services; Hamilton FHT (partial)
 - PS Suite - Hamilton FHT (partial)
 - Bell EMR - Hamilton FHT (partial)
 - Purkinje (Nightingale pending) – Community Health Centres
2. **Identify/create a mechanism for including data from health service providers not identified in #1 and from relevant social service providers, beginning with those who are partners in the HCHL:**
 - Alternatives for Youth

- Brain Injury Services of Hamilton
 - CMHA, Hamilton Branch
 - Good Shepherd
 - Hamilton Program for Schizophrenia
 - The Hamilton Clinic
 - SAM Program
 - Wayside House
 - Wellbeings
 - Long-term care facilities
3. **Identify/create a mechanism for including data from the patient and their support network.** This data includes:
- Documentation of experience and reflection on encounters with circle of care
 - Measurements taken at home (e.g. blood glucose, BP, etc.)
 - Other data capture as relevant to care plan – requires flexibility within system for patient to create/customize fields
4. **Identify/create a mechanism for secure communication between each patient and their full circle of care, and between members within that circle:**
- Provider to Provider (based on implied patient consent)
 - Patient to Provider (based on mutual consent)
 - Patient to Support Network, which may expand to include other patients (based on mutual consent)
 - Support Network Member to Provider on behalf of Patient (based on patient consent for proxy and provider consent)
5. **Identify/create a mechanism for sharing resources and supportive tools with patients and their support network:**
- Customized Care Plans
 - Educational Materials/Links
 - Self-Assessment Tools
 - Integration of eTools to enable improved health self-management

Potential Approaches to Closing the Gap

In exploring potential solutions for each gap identified, five core principles are central:

1. The solution(s) identified must work at the minimum level of the LHIN rather than just the HCHL, as the same organizations will need to participate in the information systems for the other Health Links yet to be created within the LHIN.
2. The goal is to enable providers to benefit from the integration through their existing systems wherever possible and financially feasible rather than requiring them to interact with a separate system.
3. The solution(s) must complement – not duplicate – what exists, and improve workflow and ease of diverse levels and types of reporting across sectors.
4. The solution(s) must align with known/planned LHIN and provincial eHealth strategies. This includes integration with ClinicalConnect.
5. The solution(s) must be sustainable and cost-effective, and present no financial barriers to provider or patient engagement.

Focus of Year 1

The focus of the Hamilton Central Health Link in Year 1 related to the Integrated Point of Care Information System (IPOC-IS) has two key underlying assumptions:

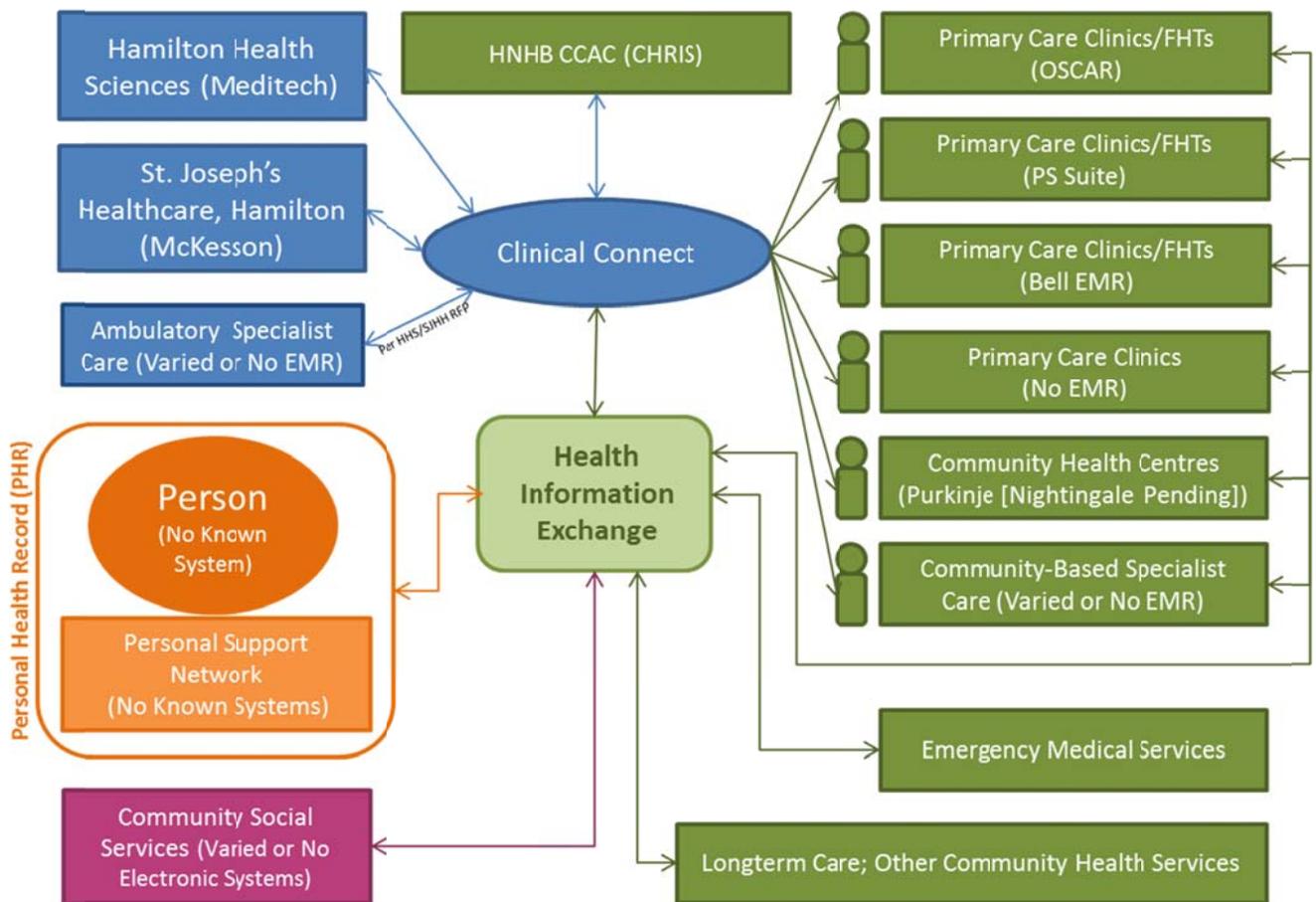
1. The degree of connectivity within the LHIN currently makes closing the identified gaps and achieving a fully connected community a realistic goal by the end of 2014, and
2. A 30-35% greater investment will achieve an integrated solution for the entire LHIN rather than just for the Hamilton Central Health Link while delivering transformational instead of incremental benefits across the LHIN and potentially beyond (particularly to other LHINs with ClinicalConnect).

Within this context, the Hamilton Central Health Link will:

- Lead the analysis and definition of requirements for the IPOC-IS in collaboration with relevant stakeholders within the LHIN and province;
- Inform the LHIN strategy for implementation and sustainability of the IPOC-IS, including contribution of funding support from Hamilton Central Health Link budget in proportion to percentage of LHIN population served;
- Participate in the procurement of technology(ies) required to create the IPOC-IS; and
- Lead adoption of the IPOC-IS with concurrent evaluation of impact.

Figure 5.

Potential IPOC-IS Solution



Note: LHIN may incent or provide use of a connected EMR for all LHIN-funded programs or initiatives to enhance integration.

To achieve the IPOC-IS in accordance with the five principles cited above, three initiatives are required (in order of priority):

1. Implement a Health Information Exchange (HIE) to manage information flow between ClinicalConnect and the community.
2. Implement a Personal Health Record (PHR) connected to the HIE to bring the patient and her/his support network into connection with all of their services.
3. Provide (or incent adoption of) a connected EMR/front-end solution for community-based health and/or social service agencies that are currently paper-based.

These three initiatives are required to support the work of HCHL serving 10% of the LHIN's population, however, with an estimated 35% more funding the same initiatives will extend to serve the remaining 90% of the population in the LHIN.

2.2.5 Support Clusters

Our work will require support from experts in several areas in order to progress effectively. This expertise is, for the most part, already available within the LHIN and among a variety of partner agencies. At this time, we have identified the following *support clusters* that have already been intimately involved in our early work and in developing this business plan.

Data Analysis Support Cluster

The HNHB LHIN and its members are well positioned to provide the necessary data analytic support to the HCHL in terms of expertise and skills across the broad sector of partners and organizations involved. Training and education in the hospital sector, CCAC sector, CHC sector, and within the LHIN itself on IDS is extensive, as well as the positioning of FHT ability to access and use ClinicalConnect. Currently a governance structure exists under the HNHB LHIN eHealth Steering for ClinicalConnect, IDS, other integrated systems, and other regional technology systems such as the Regional Oncology System (MOSAIQ) implementation, to ensure coordination, standardization, and knowledge across the LHIN. The IDS Operations Committee, which reports to the LHIN eHealth Steering, is comprised of skilled decision support leaders and analysts who will work together on HCHL metrics and monitoring, as well as other Health Links as they roll out across the LHIN. Using this Operations forum to provide a framework to support the clinical work and partners at the table in their need to understand the data, monitor progress, measure changes, and ensure quality improvement goals are being achieved will be part of the role of this group on an ongoing basis. As other additional data is needed from other sectors this support cluster will include the key analytical partners as part of the forum.

Privacy Support Cluster

We have begun, and will continue to draw mainly upon the expertise of privacy officers within Hamilton Health Sciences. This is a summary of the privacy principles that will guide our work.

On November 1, 2004, the Personal Health Information Protection Act (PHIPA) came into force in the province of Ontario. PHIPA sets out rules that individuals and organization (also referred to healthcare information custodians, HIC) must follow when collecting, using and sharing personal health information. HICs involved in delivery of health care include:

- Healthcare providers such as doctors, nurses, dentists, psychologists, optometrists, physiotherapists, chiropractors, massage therapists, dieticians, naturopaths and acupuncturists
- Hospitals
- Long term care homes and homes for special care
- Community Care Access Centre
- Pharmacies
- Medical laboratories
- Local medical officer of health
- ambulance services
- community mental health program
- the Ministry of Health and Long Term Care

When the patient seeks health care from a HIC, the HIC can assume that they have the patient's permission/permission of the patient's substitute decision maker where the patient is not capable to consent to collect, use and share the personal health information among the health care providers who provide or assist in providing health care to the patient. HIC's may also give patients personal health information to other health care providers outside the organization so that they can provide the patient with ongoing health care and follow-up.

Except where required by law, a HIC must seek the express consent of the patient or the patient's Substitute Decision Maker to give the patient's personal health information to people who do not provide health care or assist in the provision of healthcare to the patient. People outside the health system who receive personal health information can only use it or give it out for the reasons that they received it or as allowed or required by law.

The HCHL project will utilize both the assumed implied consent model and the express consent model for the collection, use and disclosure of personal health information. A subset of patients who meet specific criteria and considered eligible (top 5% cohort) will be extracted from the Integrated Decision Support (IDS) tool. From the list of eligible patients generated those names will be provided to the HIC:

- For patients that are active and receiving ongoing care, services for the patient will be coordinated amongst the agencies/custodians, assuming the implied consent of the patient.
- For those that are not currently receiving care, and the hospital (HHS, SJHH) is the HIC, there will be a flag placed in the HIC source system. In the event the patient presents in the system for care a referral to CCAC Rapid Response team will be made.

Express consent from this same group of eligible patients is obtained by the HIC. The express consent is for sharing of the patient's personal health information in non-health care activities, for example the 'Learning Circle' and for follow-up surveys.

2.3 Documentation of Health System Transformation

2.3.1 Economic Evaluation

System level economic evaluation will be conducted to determine if costs have been reduced for the top 5% of acute hospital discharges (7,235) and the top 5% of ED/UCC visits (43,476). Expertise in economic evaluation has been secured through Dr. Ron Goeree, Program for Assessment of Technology in Health, Department of Clinical Epidemiology and Biostatistics, McMaster University.

2.3.2 Measuring Health System Transformation

The outcomes of greatest importance in the goal of health system transformation are changes in behaviour, relationships, activities and attitudes. A methodology referred to as Outcome Mapping has been used extensively to document and measure social transformation such as we are aspiring to. The changes we expect are complex, continuous, non-linear, incremental and cumulative. They are beyond the control of our work (but subject to its influence) and we need to be able to document this. Our ability to be attentive along the way is as important as getting to any destination.

In the next 2 months we will work with our partners to agree upon progress markers—a graduated set of statements describing changes in behaviours of relevant organizations. These will facilitate mid-course corrections, articulate complexity of change, stimulate and stimulate us to consider how we can contribute to the most profound transformation possible. Each partner will need to consider what its major outcome challenge will be, and to reflect over time upon how well it is reaching this.

We will use strategy maps to understand how well we are doing at moving through our progress markers, whether we need to change course, or there are lessons that need to be integrated into the progress markers. We will use evaluative thinking, documenting a story of challenge and reasons for change, actors and factors that contributed to that change, unexpected changes, how we know the change occurred, and what we have learned.

We will distribute 3 questions at the end of every group experience: When did you feel most engaged, when did you feel least engaged, and what changed for you between the beginning and the end of the encounter. The questionnaires will be analyzed by the operations group on a quarterly basis. In addition, we will carry out brief qualitative interviews with participants of the Learning Circle about the impact of this experience on them and their organization. These will be communicated to the entire group or partner organizations.

Through these reflective exercises we will pay attention to where transformation is taking place, and in this attention we will also be creating our transformation.

3.0 Patient/Family Engagement

3.1 Core Concepts of Patient Engagement

Patient (and provider) engagement is a continuum. There are core concepts which guide this process and support an increasingly important role in the audibility of the voice of the community. Providers, patients and families must be invited to share their experience and this experience must be heard in the presence of openness, trust and a willingness of the listener to be introspective.

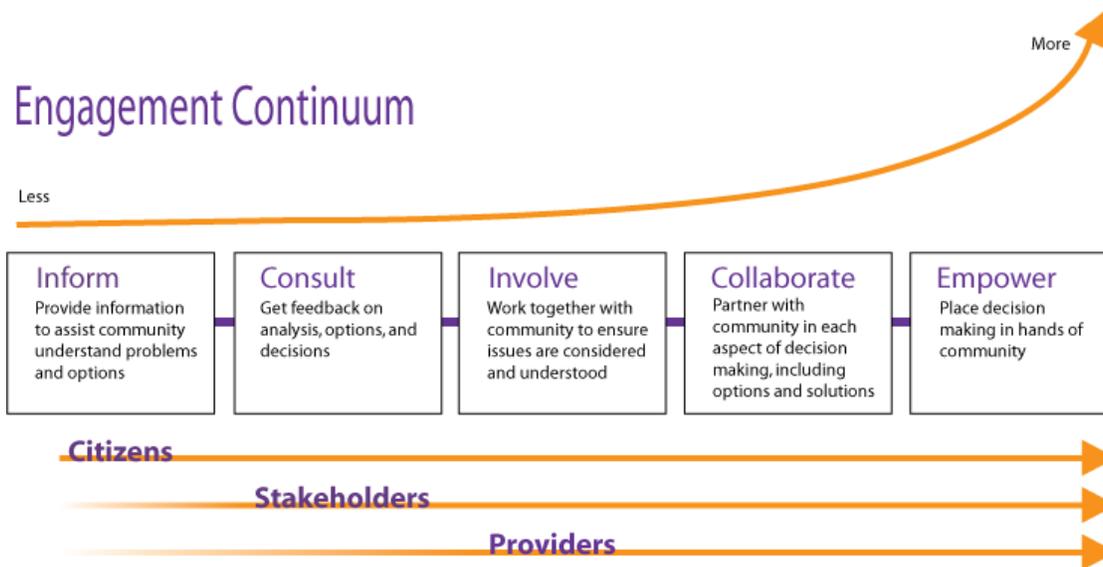
Dignity and Respect (R) Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

Information Sharing (I) Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.

Involvement/Participation/ Support (S). Patients and families are encouraged and supported in participating in care and decision-making at the level they choose. The issues are clarified and understood by the team from and with the patient's perspective.

Collaboration/Empowered (E) Patients, families, health care practitioners, and health care leaders are empowered to collaborate in policy and program development, implementation, and evaluation. In the presence of information the decision making process is in collaboration with and in the hands of the community. (<http://www.ipfcc.org/advance/topics/primary-care.html>).

Figure 6. Engagement Continuum <http://www.hnhblhin.on.ca>



3.2 Engagement Strategies

The patient's story of their lived experience, their interpretation of that lived experience and the description of that experience is essential to the discussion related to health care transformation. Each patient has a story and the gathering of that story will be successful only if the patient understands that their story is heard. This requires the fostering of a trust relationship with

the patient and is often linked directly to the relationship of the caregiver or provider to the patient. Gleaning and listening to the patients' perspective will be a key success factor to health system transformation. Understanding the narrative context of illness provides a framework for approaching a patient's concerns holistically, as well as revealing diagnostic and therapeutic options.

The recounting of the patient story through the voice of the provider/caregiver is one of the first steps in engagement. Identification, contact and connection with patients/family members would be through the collaborating partners and providers. Each provider has a repository of experiences they have been involved in and they will be approached to share these experiences. While the patient's own voice and perspective is essential, the provider's retelling of that story will begin the process of sharing the experience with the team in an effort to focus on individual and system issues simultaneously.

The patient's personal narrative is the second important step in the process of engagement. Engaging patients in the exercise of narrative may be challenging but also very valuable. This is not because they don't have anything to say but rather, the assurance that their story is important and respected and the forum within which they tell the story is safe. The safe environment will be one where there is no fear of repercussion from those who hear the story, where the listener will 'be aware and really listen and understand' and where the story teller will be free to share the burden and weight of the experience¹. It is essential that the listener understand not just the encounter, but that encounter in the context of the patients' lives. Narratives will be solicited from both patients and caregivers/families. The social animator will be integral to this process. They will work with the providers to engage patients in this process, work with patients to hear and collect the story. A non-judgemental, engaged, and active listening team must be in place to support the honest telling of the narrative.

Collecting the Narratives

It is important that patient directed narrative be facilitated to be received in a variety of formats. This patients' voice will point us to where the challenges are, what work has to be done to reduce the gap, and signal our priorities. The social animator is an essential part of this collection. Their role will be to engage the provider and the patient in the details related to the story. Through these conversations and with the direction of the social animator, each participant will be able to articulate their journey through story telling/narrative in such a way that the patient's voice is heard and the team (system) begins to clearly see and appreciate the challenges, gaps and opportunities experienced during this journey.

The Provider-patient Narrative

In phase 1, providers will be invited to share patient stories. These stories will describe a patient experience from the perspective of the provider. This 'second-hand' narrative may not be from the patient directly, it will carry the voice of the patient. This story might be articulated by the provider and with the help/support of the social animator. These stories will originate at the provider in the initial months only. It is the expectation that the patient, when engaged in the process, will also work with the social animator to give their voice to this process.

During phase 2, the gathered narratives will be collated and considered by the Learning Circle. Themes will be identified and labelled for frequency and commonality. This new knowledge will inform the leverage points/potential barriers and will support the Learning Circle to develop strategies for addressing these barriers.

Telling the Story

You are being asked to talk about or write about your experience with people who provide services to support you and your health.

What was the issue/problem?

Describe this issue/problem in terms of:

- Time (When did it happen?)
- Place (Where did it happen?)

- Participants (Who was involved?)
- Circumstances (How did this incident happen to come about?)

List the sequence of events that occurred during the incident:

- What happened first?
- Then what happened?
- What happened finally?

What did the event mean to you at the time? Why did things happen as they did? What does the event mean to you in your life now?

The primary areas where collaboration with patients will be important and necessary. As former or current patients and/or families, these mentors understand and can articulate their experiences within the health care setting and beyond. This unique perspective will inform the discussion and influence the method and evaluation of current practice and potentially alter future initiatives.

4.0 Resource Plan

The methodology used for resource allocation was to first look internally for both expertise as well as availability of specific resources. If expertise was present then availability was attempted to be created via reallocation of other existing resources. If the Resources were not available internally then recruitment was required and market rates were used with the Budget Proposal. In this section, existing resources and direct resources are discussed. Please see Attachment D for the Budget Summary as well as Attachment E for the Work Plan Summary.

4.1 Existing Resources

4.1.1 HNHB LHIN

In its role as a facilitator/enabler, the HNHB LHIN is committed to the successful development, implementation, evaluation and ongoing sustainability of Health Links. The HNHB LHIN will commit a variety of resources to the initiative, including but not limited to the following:

- To develop and promote a common and consistent Health Links message
- To support communities and organizations in securing the commitment of healthcare providers, hospitals, the CCAC and community partners
- The provision of data relating to the high user cohort (the target population)
- The provision of high-level data analysis
- Clinical integration expertise
- On-going performance management guidance
- Planning expertise with regards to key benchmarks (i.e. readiness assessment, business plan, implementation, indicator monitoring, evaluation)
- Supporting accountability with regards to funding allocations
- Facilitating support, where appropriate, regarding general topics relevant to Health Links in general (i.e. technology/connectivity, privacy/consent)
- Engaging the support of strategic partners through the Provincial Health Link Advisory Table
- Building capacity with regards to quality improvement processes through existing partnerships (i.e. Health Quality Ontario)
- Clinical leadership development for Health Link representatives
- Ensuring that the MOHLTC is aware of identified barriers and challenges.

4.1.2 HNHB CCAC Existing Resources

HNHB CCAC connect people in our region with the health and support services they need to remain at home, avoid hospital admissions, access support upon discharge from hospital and explore long-term care options

The following lists existing resources will be leveraged to support implementation Activities Year 1:

The HNHB CCAC is an integral partner in the coordination and delivery of health services across the HNHB Local Health Integration Network. We work collaboratively with our partners and patients to meet their health care needs at the point of care. The following will provide a brief overview of the HNHB CCAC existing services and how these can be leveraged to **“improve coordination of care for those who need health services the most”**.

Care Coordination

Many of our existing patients are dealing with multiple and complex conditions and as a result require the expertise of care coordinators to coordinate appropriate health and community services in order to remain at home. The care coordinator plays a vital role which includes assessment and system navigation to successfully meet the needs of the complex patients. For complex patients the care coordinator works collaboratively with the health care team to provide intensive case management. In addition the care coordinator has the skill, experience and expertise to work collaboratively to reduce hospital admission rates

Health Links Strategy:

- Care coordinator(s) will be connected to each of the individuals who are CCAC patients who are in the top 5% (approximately 140 individuals) who frequently use the inpatient and emergency hospital services. We anticipate the need for 3 intensive care coordinators.
- For the remaining 50% we will connect with them (via a referral process under development resolving privacy issues) and determine if CCAC care coordination is primarily needed, or referral to a mental health hub of providers is actually more appropriate to meet the client needs. This model is to be developed but the CCAC is willing to work with partners to examine/resource the best care coordination for these patients.

Care Coordination in Family Health Teams

Currently there are care coordinators integrated into Family Health Teams as a single point of contact for care coordination in the Hamilton Branch. The care coordinator meets regularly with the patient's Primary Care Practitioner to share information and develop coordinated care plans.

Health Links Strategy:

- The Health Links strategy will build on Primary Care attached care coordinators. Shared information and coordinated care planning will continue and evolve to support high use patients.
- The CCAC is expanding its care coordination model to solo practice primary care physicians and CHCs.

Clinical Programs

Rapid Response Transitional Team

Recognizing that complex patients in the community require clinical support the CCAC is building programs of direct clinical service. This program includes the expertise of registered nurses, nurse practitioners and pharmacists. Services include a home visit within 24 hours of hospital discharge, medication reconciliation, comprehensive nursing assessment, patient/family education, linkage with primary care physician within 7 days post hospital discharge for primary care follow-up. For the medically complex patient with medication concerns, an in-home pharmacist is available to perform an in-depth medication assessment and reconciliation. The goal of the program is to reduce 30 days readmission rates. Currently 50% of patients seen by the RRTT nurses have a diagnosis of CHF and COPD. The RRTT are providing expert clinical management for patients who transition home from hospital.

Health Links Strategy:

- We will build on the advanced practice / nurse practitioner role. In addition to following the patient into and support them during the transition home from

hospital, the APN will support the patient for a period of time (Naylor model), to improve chronic disease management in collaboration with the primary care provider, promote connections to primary care and provide medication management.

Palliative Nurse Practitioner

Imminently the HNHB CCAC will enhance their integrated palliative care program with the addition of nurse practitioners. The role of the nurse practitioner will be to:

- Build regional capacity for 24/7 palliative care
- Support and enhance capacity of primary care practitioners providing palliative care
- Reduce hospitalization/avoidable emergency department visits for palliative clients
- Enhance quality of palliative care by pain and symptom management and by supporting individuals in dying in their place of choice (including home) through Nurse Practitioners advanced scope of practice
- Advance care connections across health care sectors for seamless, coordinated and integrated palliative care.

Health Links Strategy:

- Adding the NP role to our palliative care program will enhance our ability to support complex palliative patients at home.

Health Care Connectors

Health Care Connect is a program designed to help patients without a regular family health care provider find one in their community. The Program identifies doctors or nurse practitioners who are accepting patients and links them with people who are in need of a family health care provider. The HNHB CCAC has been successful in connecting 95% of all referred patients to an appropriate health care provider. In addition 97.2% of those identified as having high needs were successfully connected to a health care provider.

Health Links Strategy:

- For those patients who are not connected to primary care, the Health Care Connector will work with the patient to connect the patient with a family health care provider.

4.1.3 Hamilton Health Sciences

The following lists existing resources will be leveraged to support implementation Activities Year 1:

Hamilton Health Sciences is comprised of six unique hospitals (General, Juravinski, Children's, McMaster, St. Peter's, and Chedoke), an urgent care centre and a cancer centre. We provide inpatient care (both acute and post-acute), and offer a number of ambulatory clinics that could have a significant impact on the patient population identified in the Hamilton Central Health Links. As described earlier, the identified high users had a few key reasons for their emergency department visit (COPD, heart failure, abdominal and pelvic pain, mental health or substance abuse) and hospital admission (COPD, cardiac issues, urinary disorders).

Similar to our other health care partners in the City of Hamilton, we are ready to provide access for the identified high users to our hospital services: for both acute inpatient services as well as expedited access to our outpatient clinics in order to avoid an emergency department visit and potential hospital admission.

Although the number of resources to draw upon at Hamilton Health Sciences is vast, the following is a list of key resources that could be very helpful during Year 1 to serve this compromised patient population:

A. *Outpatient Clinics and Services aimed at preventing ED visits and/or readmission to hospital*

- General Internal Medicine Rapid Access Outpatient Clinic
Assesses urgent medical patients by a physician and other multi-disciplinary professions in a timely manner.
- General Cardiology Clinic
For patients with chest pain, atrial fibrillation, or any other cardiology related complaint/diagnosis.
- Heart Function/Heart Failure Clinic
Case management for patients with congestive heart failure.
- Arrhythmia Services Clinic
For patients with low heart rate, palpitations, dizziness.
- Pacemaker Clinic
Provides rapid access for patients with an implanted heart device to ensure proper functioning of device
- Adult Congenital Cardiac Clinic and the Special Cardiac Pregnancy Clinic
MDs and one NP who provide holistic care. Help bridge gaps in the long term and not just with cardiac issues – monitoring of heart failure patients and case management.
- Adult GI Clinic
Prompt access IBD clinic for patients having exacerbation of symptoms are seen promptly.
- Mental Health Supportive Care at Juravinski Cancer Centre
Manages patients in an out-patient setting to avoid admission to a mental health unit during cancer treatment
- Diabetes clinic
Some spots available in clinic schedule to accommodate patients with urgent diabetic needs.
- Centre for Healthy Aging
Outreach Team – is an interdisciplinary group of case managers and physicians who stay connected via telephone with their patients.
- Neuroscience Ambulatory Clinic
Manages the needs of stroke, neurosurgical, spine, epilepsy, concussion, Neurology and Neuro-interventional patients involving health care maintenance pre-operatively and post operatively by an interdisciplinary team.
- Stroke Prevention Clinic
Provides early, facilitated access to neurological and diagnostic testing, evidence based treatment, and health teaching for persons who may have experienced a mild non-disabling stroke or TIA.

Further to the resources listed above, Hamilton Health Sciences is leading or supporting multiple initiatives with benefits that will apply to the identified patient population. As these initiatives are planned and/or implemented, they may be adaptable to specifically address the identified high user patient population.

- *Reducing Emergency Department visits from Long-Term Care*
General Internal Medicine physicians and staff of the Quality, Patient Safety and Risk program at HHS is collaborating with the long-term care (LTC) sector in Hamilton with a research project exploring LTC resident transfers to the emergency departments. The purpose of this research is to identify the various reasons that residents are sent to acute care with the goal of identifying strategies that will prevent transfers, either by offering other locations for residents to have assessment (after a fall, for example), or by advocating for access to these services in the LTC home setting by having the services go to the resident.

- *Optimizing Care for Frequent Users of Emergency Departments in Hamilton*
In partnership with SJHH, with funding from the HNHB LHIN Emergency Services Steering Committee, HHS ED physicians and social workers liaise with a Healthcare System Navigator working with frequent adult ED visitors.
- *HNHB LHIN Discharge Transitions Bundle Project*
Hamilton Health Sciences has helped lead this project focused on reducing avoidable admissions for COPD. Additional funding requests have been initiated for spread of the bundle and expansion to other high-frequency readmission case-mix groups (e.g., Heart Failure).
- *Improving an already extensive IT and Decision Support technology*
Integration through shared data repositories (IDS), clinical decision support EMR (ClinicalConnect), Regional Oncology Clinical and Information System (MOSAIQ), as well as the e-Care online physician and nursing documentation and order entry project roll-out.

Lastly, Hamilton Health Sciences is committed to supporting HCHL with various expertise (depending on need) including, but not limited to:

A. *Facilitation of Quality Improvement initiatives*

There may be a need to restructure how patients are scheduled in the outpatient clinics above, if it is determined that the identified high users might require urgent/rapid access to a clinic. Hamilton Health Sciences is committed to applying some internal quality improvement resources to these types of improvement projects. HHS has experience in the application of Lean principles and simulation modeling to improve clinic patient flow and resource utilization, and has also begun development of software to assist with real-time clinic “traffic control”. HHS has partnered in these applications with the Centre for Research in Healthcare Engineering (University of Toronto) and with the Resource Allocation and Stochastic Systems Lab (McMaster University).

B. *Other expertise available*

Hamilton Health Sciences has many other individuals with expertise that can contribute to the success of Health Links such as building custom queries from IDS, Privacy Officer consultation, Inter-professional Practice practitioners and educators, and other health care system leaders that are available for support.

4.1.4 *St. Joseph’s Healthcare Hamilton*

St. Joseph’s in Hamilton represents the Hamilton-based members of the St. Joseph’s Health System. St. Joseph’s Healthcare Hamilton (SJHH), St. Joseph’s Villa (SJV) and St. Joseph’s Home Care (SJHC) are integrated under one community board to realize excellence in quality and safety, transitions of care, and research and education. Specifically, St. Joseph’s Healthcare Hamilton is an academic and research hospital focused on improving the lives and health of our community through the delivery of integrated health service. SJHH provides acute care and tertiary level care in signature programs including kidney care, respiratory diseases and thoracic surgery, bariatric surgery, an extensive general medicine program and specialized mental health services. The hospital also delivers ambulatory care at specialised referral clinics, outpatient surgery and an urgent care centre at its King Campus. Our more than 4,000 staff are committed to ongoing excellence to further the Mission of our founders, providing care with dignity, compassion and respect. SJHH is affiliated with McMaster University, Mohawk College, and the St. Joseph’s Health System.

SJHH currently provides many services and programs on an inpatient, ambulatory, community and outreach basis that have the potential to interface within this new model. Given the particular needs of each patient and the necessity for focused planning that meets the specific needs of the individual, SJHH is committed to providing rapid access to any of our specialty inpatient or ambulatory services as they are needed. This could include services offered by Crisis Outreach and Support Team (COAST), diabetes outreach, speciality clinics such as Firestone Respiratory Clinic and Internal Medicine Rapid Assessment Clinic or non-medical services lead by therapeutics or nursing staff. Moreover, we are currently working intensely across our services and teams to

strengthen structure and mind-set in building and preserving clearer communication and integration with all providers and agencies that share in the care of patients that receive services at SJHH.

The following lists some of the existing resources of SJHH that can be leveraged to support implementation activities in Year 1.

A. Ambulatory Clinics:

- **Internal Medicine Rapid Assessment Clinic** provides **urgent** medical assessment and interprofessional consultation for individuals who have an acute presentation or exacerbation of an existing medical condition such as COPD or CHF.
- **Firestone Urgent Assessment Clinic** provides individuals with assessment and management of respiratory disease with referrals to other subspecialties as required and offers strong linkages to family practitioners.
- **Diabetes Clinics** provide assessment, education, treatment and support for individuals with pre-diabetes and diabetes.

B. Mental Health and Addiction Services:

- **Community Psychiatry Program** offers a Primary Care Consultation Stream (“Rapid Consult Clinic”) for family physicians to assist them in the on-going care of patients with psychiatric disorders.
- **COAST** provides a range of accessible services through a mobile crisis team that include outreach, assessment, support and interventions to help prevent further crisis. This program is a collaborative community initiative with SJHH and the Hamilton-Wentworth Regional Police.
- **Assertive Community Resource Team** delivers specialized community-based services to people with complex physical, psychological and social needs due to severe mental illness accompanied by significant functional impairments, disruption so normal life tasks, periods of hospitalization and need for psychotropic medication.
- **Cleghorn Early Intervention in Psychosis Program** provides rapid and specialized assessment, treatment and rehabilitation for people experiencing a first episode of psychosis.

In addition, St. Joseph’s in Hamilton is currently involved in several projects and initiatives that are aligned with the proposed work of/ or involving some of the patient populations identified to be served through the Health Links model. The demonstrated positive clinical and system outcomes and patient satisfaction evidenced by these projects will offer valuable insights and could be available to provide services for specific patients.

- A. **Integrated Comprehensive Care – Bundled Care Project:** This is an innovative model of care that directly integrates hospital (SJHH) and community care services (SJHC) for individuals within specific clinical domains including chronic diseases (COPD, CHF). The Integrated Care Coordinator coordinates transitions throughout the patient’s journey and is responsible for exchanging knowledge related to respective health conditions and the continuum of services and resources to enhance client self-management and quality of care. This project has been successful in designing simple data bases and utilizing readily available communication tools (e.g., iPads, Skype) to maximize coordination and engagement amongst patients and service providers.
- B. **Optimizing Care for Frequent Users of Emergency Departments in Hamilton:** This project funded by the Emergency Services Steering Committee, HNHB LHIN is a joint initiative with Hamilton Health Sciences and SJHH. A client centered intervention involving a Health System Navigator works with individuals who are high users of Emergency Department Services across Hamilton.
- C. **Avoidance of Emergency Department Visits and Transfers:** St. Joseph’s Home Care and St. Joseph’s Villa as part of their respective Quality Improvement Plans have focused

on supporting individuals in their current living environments in order to avoid presentation to Emergency Departments.

St. Joseph's in Hamilton is also prepared to support Health Links with specific additional commitments as follows:

- a "Navigator"/"Coach" to fulfil the care connector role for a designated group of individuals as part of a pilots/small tests of change
- participation at the learning table
- piloting such initiatives such as "flagging and tagging" for patients who have repeated presentation for ED and hospital based services with the goal of providing rapid implementation/reinforcement of established care plans and communication with community based partners to optimize care and outcomes
- clinical, education and research expertise and leadership, specifically in respiratory disease and mental health and addictions
- opportunities for access to newly developed ambulatory clinics and services with the intended focus on multidisciplinary care of patients with chronic diseases at the Margaret and Charles Juravinski Centre for Integrated Healthcare in 2014
- IT integration

4.1.5 City of Hamilton

City of Hamilton provides a variety of services to 520,000 residents. Our Mission is to provide quality public services that contribute to a healthy, safe and prosperous community in a sustainable manner. These include infrastructure services such as roads, waste, water and sewer; health and social services such as public health services, long term care and recreation programs; and emergency services such as fire and paramedic services. The City of Hamilton is also the Service Manager for programs such as childcare, housing and social assistance (Ontario Works). The City of Hamilton is committed to working with residents, community organizations and other institutions to ensure services are coordinated with our partners.

The following lists existing resources will be leveraged to support implementation Activities Year 1:

Public Health Services

- Participation on the Advisory Board (Medical Officer of Health)
- Participation with the Learning Circle as required
- Linkages with Mental Health & Street Outreach Services. This program links individuals who have a diagnosed mental illness or are homeless/poorly housed to appropriate supports and services. Some of these individuals may be frequent users of the Emergency Department

Hamilton Paramedic Services:

- Participation with the Courage Table as required
- Leverage Paramedic capacity to provide additional supports to individuals who frequently access the Emergency Department
- Participate in seeking changes to the MOHLTC policy that currently propels ALL patients to go the emergency department and instead will encourage patients better suited to other alternatives will be to make those choices

Neighbourhood Development Strategy:

- Participation on the Advisory Board
- Linkage to residents in priority neighbourhoods (many of which overlap with Health Links geography)
- Support for development of engagement strategies at the community level

In addition, linkages can be made to additional City services and resources that can assist with planning and delivery of new service models to the community. The staff who are directly participating in the Health Links initiative will act as a liaison with other departments at the City of Hamilton as needed.

4.1.6 Other Partner Organizations

Table 3 lists existing resources that will be leveraged to support implementation Activities Year 1:

Table 3: Organizations

Organization	
<p>AbleLiving Services Inc. offers a range of community support services, based on the independent living model. Services are provided to approximately 800 individuals with disabilities in numerous locales spanning across the HNH B and Mississauga Halton LHIN's. Personal attendant care, supportive housing, caregiver respite, housekeeping, limited transportation, nursing and therapeutic services are among the services provided to clients.</p>	
What will your contribution be	What resources will you be able to contribute in-kind
<p>AbleLiving Services Inc. has significant experience and expertise in working with individuals with disabilities in the community. The organization is committed to providing a range of services and supports that allow individuals to remain in their own homes. Outreach attendant care and homemaking services along with the completion of a Home Risk Assessment and the interRAI Community Health Assessment as well as referral to appropriate supports in the community are among some of the ways we can contribute to the initiative. AbleLiving is actively engaged with the BSO and recognized as an ICL in Hamilton and Burlington. St. Peter's Residence at Chedoke has significant experience in the area of senior care. We can provide expert knowledge with respect to working with seniors as well as specialized experience working with individuals with dementia.</p>	<p>Consultation and expert knowledge in working with individuals with disabilities, seniors and individuals living with dementia. Education and training to professionals relating to working with individuals with disabilities and/or seniors. Facilities and limited administrative support. Home Risk Assessments. Linkages and referrals to the service provider network.</p>
<p>Alternatives for Youth is a community based addiction and mental health treatment program for children and youth ages 12-23. Alternatives For Youth provides addiction and mental health screening and assessment, early intervention and brief treatment, and treatment for youth and families. Clinical services are delivered on-site in secondary schools. Specialized programs include youth with concurrent disorders, pregnant and mothering youth, street involved youth, and early intervention for youth experiencing first episode psychosis. Clinical services are provided in collaboration with other service providers i.e. St. Joseph's Health Care.</p>	
What will your contribution be	What resources will you be able to contribute in-kind
<p>Represent and advocate for the specific population of children, youth and their families who have addiction and mental health concerns.</p>	<p>Expertise and consultation specific to this population, expertise and consultation related to the principles of system improvement.</p>
<p>Brain Injury Services is a community based provider of rehabilitation services for adults with acquired brain injuries. Service continuum extends from 24 hour supported residential, through outreach and day programs, with a focus on behavioural/cognitive rehabilitation, vocational/academic support, case management, consultation and education.</p>	
What will your contribution be	What resources will you be able to contribute in-kind
<p>Support of and participation in this initiative in any way that would be helpful.</p>	<p>Staff expertise and consultation regarding acquired brain injuries and/or other challenging cognitive or behavioural concerns; education and training where appropriate; some limited direct care; identification of alternate resources; meeting space.</p>
<p>Canadian Mental Health Association (CMHA), Hamilton Branch is a community mental health service providing programs and services to adult residing in the City of Hamilton. We offer the following; intensive case management, concurrent disorders intensive case management, supportive housing, mental health court support services, transitional case management (forensic), social rehabilitation recreation, and a primary health care clinic.</p>	

<p>Centre De Santé Communautaire Hamilton-Niagara Primary care, diabetes education, health and wellness, adult and children's mental health, violence prevention programs, early years centre, established program for new comers.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>We have agreed to come on board as a partner. We are willing to be part of discussions to develop the measures to the various indicators. We are willing to contribute to the patient narrative. We are willing to re-examine the way we conduct business in order to ensure the streamlining and enhanced accessibility to expanded services. Other contributions would be in the area of patient satisfaction surveys, or provider satisfaction surveys as well as family/patient engagement.</p>	<p>Our in kind resources includes members of our primary care team: 2 physicians, 1 nurse practitioner, 1 dietician, 1 nutritionist, 2 occupational therapists, 1 home visiting nurse, 1 mental health worker for seniors, 1 case manager. As such we would take the time required from any of these professionals to contribute to meeting the goals of the health link.</p>
<p>De dwa dehs nye's Aboriginal Health Centre De dwa da dehs nye's Aboriginal Health Centre assists Aboriginal people in accessing culturally appropriate health care programs and services. The Health Centre focuses on holistic preventative and primary health care that includes Physicians, Nurse Practitioners, Traditional Healing and other primary health services - Mental Health Support as well as community health supports - Advocacy, Outreach and Health Promotion and Education Services. The Health Centre serves all Aboriginal people, regardless of status and offers assistance to outside service organizations to provide care in a culturally appropriate way.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>Aboriginal Urban Health Expertise.</p>	
<p>Good Shepherd Good Shepherd is a multi-service, human services agency that serves men, women, youth, children and families from birth to end of life. Services and programs include HOMES Program (supporting housing for people living with mental illness), Barrett Centre for Crisis Support, Emmanuel House (residential hospice services), Core Collaborative Learning (virtual learning environment for social determinants of health), as well as a broad range of supports and services including emergency shelter, food, clothing and counselling services.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>Good Shepherd has a proven track-record as a preventative healthcare and social services provider with significant experience in providing person-centred solutions and services and administering programs that support optimal community function for individuals. Good Shepherd operates within an integrated anti-racism/anti-oppression framework and actively works to reflect the communities we serve and to respond with cultural competence to the diversity within our community. The agency actively participates in a broad range of local and regional collaboratives, networks and working groups in areas such as women abuse, homelessness, primary health care, addiction and mental health. Good Shepherds, a LHIN funded agency, is currently involved with BSO initiative with an Integrated Community Lead on staff and has participated in LHIN sponsored quality improvement training.</p>	<p>Good Shepherd can offer expertise in hosing, crisis intervention, end-of life care, case management/counselling services. Historically , we have provided in-kind resources such as: staff, administrative supports, acted as a TPA, provided training, building/facility space and access to our many networks and collaboratives in the pursuit of effective community partnerships and enhanced, person-centred service provision.</p>
<p>Hamilton Family Health Team provides increased capacity in primary care, e.g. fuller scopes of practice enhanced training, better afterhours care, more timely access to care, broader system navigation, more systematic approach to chronic disease management, population health and prevention and enhanced IT capacity for data sharing, communication and patient journey</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>Encouragement and support to HFHT practices located in the lower city to assist in the 'management' of care plans for this patient population. Training of Allied Health Professionals to better assist patients to navigate the system.</p>	<p>Some management time to assist with the strategy development and operationalizing the plan.</p>

<p>Hamilton Program for Schizophrenia is a comprehensive community-based treatment and rehabilitation program. We are dedicated to helping people with schizophrenia through case management services, rehabilitation programs and psychiatric care. We make a long-term commitment to our clients and their families.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>Represent an share understanding of the needs/wants of individuals with sever and persistent mental illness such as schizophrenia. Further to comment on best practices and support approaches to respond to individual needs for those with these types of mental health challenges.</p>	<p>Consultation</p>
<p>Hamilton Urban Core Community Health Centre is an inner city health Centre providing primary health care services and health promotion programs to individuals and families in Hamilton. We provide a wide range of services that address or respond to client and community needs such as primary health care, prevention and management of chronic and complex health conditions, education, counselling, client advocacy, community development and capacity building, outreach, system navigation, referral and other activities. The Centre also provides cultural interpretation and translations services internally and externally. Our client populations include individuals and families living in poverty, people living with mental illness and addiction, people who are homeless, immigrants and refugees, isolated seniors, and street involved youth.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>Participate as a partner. Actively participate in discussions regarding indicators and the “courage table”. Contribute to the client narrative, client engagement and gathering client stories. Examine current practices with a view to enhancing access and expanding services. Work with complex clients, share experience with marginalized high needs, complex clients. Equity and health equity expertise.</p>	<p>Expertise in working with marginalized clients with chronic and complex health conditions. Equity and health equity expertise. Client engagement. Client experience expertise. Expertise and consultation specific to the population served by the Centre.</p>
<p>North Hamilton Community Health Centre works with individuals who have barriers to the health care system with the framework of the social determinants of health using integrated and wrap around approaches. Our philosophy: Vision: No Obstacles to Health; Mission: Enable Health Through Healing Hope and Wellness. Model of Care: Use of the Broad Determinants of Health, Client Centred, Interdisciplinary. Our Team, 5 family physicians, 5 nurse practitioners, 1 physician assistant, 3 RPNs, .4 pharmacist, .2 asthma coordinator and allied health care team which includes CDM, diabetes, occupational therapist, physiotherapist, kinesiology, dietician, mental wellness, chiropody.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>IS expertise in the use of IDS. Presence at the courage table. Commitment to take 30-40 complex clients from the top 320 onto our roster. Quality improvement plan expertise in development and implementation. Accreditation expertise. Patient experience expertise.</p>	<p>IS expertise in the use of IDS. Presence at the courage table. Commitment to take 30-40 complex clients from the top 320 onto our roster. Quality improvement plan expertise in development and implementation. Accreditation expertise. Patient experience expertise.</p>
<p>Seniors Activation Maintenance (SAM) Program is a community program offering a ‘day out’ for older adults and those unable to participate in their usual social and recreational activities. SAM offers a variety of physical, social, creative and mentally stimulating activities, exercise programs regardless of abilities, hot full course meal, assistance with personal care needs including medications, transportation assistance, respite from caregiving responsibilities and a registered nurse on-site.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>The Seniors Activation Maintenance (SAM) Program is a long-standing Adult Day Service (ADS) Program with three community-based sites in Hamilton. ADS Programs offer a supported “day out” for seniors and adults with limited abilities who cannot participate in the usual or “normal” social or recreational activities because of limitations they may have. Our programs are also an important means of respite for many caregivers. ADS programs are ant is an opportunity to get out of the house and be with other people and to feel like you “belong” somewhere. Therapeutic</p>	<p>The SAM Program can offer expertise and education regarding Hamilton Adult Day Service Programs. Our Executive Director and staff will also act as a liaison and resource to the HCHL team as required based upon our ongoing collaborative work being done with other Hamilton and HNHB LHIN ADS Programs, our Regional Stroke team, the HNHB CCAC and other Hamilton community support services. Areas of interest to the project that we can assist in may include the</p>

<p>recreational and exercise activities offered promote improved or maintained mood and physical, cognitive and social mental functioning as participants can continue to attend programs as long as able. Assistance with personal care, transportation and fee subsidy is provided as required. Income, social support networks, personal health and coping skills are significant social determinants of health that can be strengthened through participation in an Adult Day Service Program. The SAM Program is one of seven Hamilton Adult Day Service (ADS) Programs with a total of 11 sites serving Hamilton residents. 5/11 of these ADS program sites are located within the Hamilton Central Health Link catchment area.</p>	<p>proposed “stroke navigator” role to assist persons in navigating complex health systems and a simplified ADS referral system through CCAC for hospital and primary care staff.</p>
<p>Shelter Health Network Shelter Health network physician group provides primary care to the homeless without a family doctor plus provides Hepatitis C treatment. Part of the physician groups also includes internists, infectious disease specialist and a psychiatrist. Primary care access for patients with complex social issues and try to decrease change of ER and prolonged hospital admissions.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>Improve on current model of provision of health care to prevent ER visits that are not needed.</p>	<p>Unable to contribute in-kind</p>
<p>Southern Network of Specialized Care (SNSC) is one of four networks that make up the Community Networks of Specialized Care. The Network is involved in linking specialized services and professionals to pool their expertise to treat and support adults who have developmental disabilities and mental health needs and/or challenging behaviours (ie. dual diagnosis) in the communities where they live. The Networks bring together people from a variety of sectors including developmental services, health, research, education and justice in a common goal of improving the coordination, access and quality of services for these individuals who have complex needs. Provincially, the Networks collaborate in the following areas in an effort to increase community capacity to support individuals with complex needs: Education, Research and Evaluation, Health Care Capacity, Specialized Services, and Resources.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>The SNSC will contribute information and suggestions regarding the challenges and opportunities to provide better and more efficient health care to people who have developmental disability, including those who experience mental health disorder and/or significant emotional/behaviour challenges.</p>	<p>Information, education, training to: health care professions, developmental service providers, and individuals who have developmental disability and their family caregivers. Linkages, communication, and collaboration with the developmental service sector.</p>
<p>The Hamilton Clinic is an addiction treatment services, primary care medical services, Hepatitis C assessment and follow-up, harm reduction and referral for detox and treatment, diabetes outreach and supportive group and individual counselling programs, psychiatric assessments.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>We strive to improve the quality and capacity of addiction treatment programming in Hamilton as well as to collaborate with services related to homelessness and to chronic mental health primary care provision.</p>	<p>Opiate dependence treatment services, support, counselling, primary care and hepatitis C care for opiate dependent clients. Some case management and counselling case management and counselling as well as support groups. Participation in Drug Court treatment teams as primary and addiction care providers.</p>
<p>VON Canada – Ontario Branch provides Home Care (professional nursing services), Adult Day Programs for clients with dementia, overnight respite for clients with dementia, care giver support (primary for care givers of clients with dementia), in home respite (PSW's provide 10-20 hours per month for care giver relief (\$5/hr), hospice/bereavement volunteer visiting and Meals on Wheels.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>VON in HNHB provides professional home nursing services and PSW services. In addition, the VON offers several volunteer driven programs, with over 600 active volunteers</p>	<p>Volunteers trained in working with the frail elderly and clients with dementia. The development of programming to support the achievement of LHIN</p>

<p>trained to support frail elderly in areas such as Palliative/bereavement, social isolation, and safety and security. These programs have demonstrated the ability to enhance and extend professional services such that ER access and ALC days are further minimized.</p>	<p>and HCHL strategic priorities.</p>
<p>Wayside House of Hamilton is a residential addiction treatment and supportive housing for adult men 18+. Specialize in addiction to alcohol and/drugs, concurrent disorders and ABI. 20 beds residential treatment and 31 supportive housing beds. Comprehensive Hepatitis C outreach, diagnosis, treatment and case management support directly connected to Shelter Health Network.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>My contribution would be my time. Assist in committee or planning work/tables. I am on the executive with the Addiction and Mental Health Association of Ontario and would have access to provincial resources and data. I chair the Hamilton Addiction System Committee and past chair of the Hamilton Addiction and Mental Health Collaborative. Thus have access to local planning and resources. I co-chair the Addiction and Mental Health Network of the HNHB LHIN with access to LHIN planning and other mental health and addiction leads. I am president of the Shelter Health Network board of directors which I share with Anne Childs. Again, access to planning tables and access to direct issues and concerns to the population in question.</p>	<p>In-kind, perhaps photo copy, mailing, stamps etc. Nothing too extensive. My in-kind would be more my time.</p>
<p>Wellbeings Pain Management and Dependency Clinic Inc. provides a multi-disciplinary medical team for pain, addiction and mental health. Counselling services are offered (CBT and Mindfulness Meditation) by one of our physicians. Our physicians and health care team work together to titrate opioid use where pain and addiction are concurrent. Trigger point injections are used to reduce pain and pain management services are offered. Methadone Maintenance Treatment (MMT) services are provided and Suboxone™ is also available. There is a lab on-site for Urine Drug Screening (UDS). Wellbeings is a best-practice, evidence-based multi-disciplinary model, unique in our community.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>Wellbeings is a multi-disciplinary clinic that offers front-line medical treatments and pain management and advocates for people who live in pain or suffer from addiction to opioids or both. Wellbeings will also be offering psychiatric care in the Spring of 2013 making it a unique community clinic. CBT and Mindfulness Meditation are currently offered in group sessions. The Medical Team at Wellbeings changes lives by bringing people and knowledge together to provide timely access to care, improve medical care, reduce stigma through education and publish evidence-based research.</p>	<p>Select members of the Wellbeings' Team will contribute their personal time to the development of the Business Plan. The physicians at Wellbeings will be able to take referrals from people's Family Physicians as well as from sister partners in the HCHL program to ensure that people get the medical help they want and need. Wellbeings' physicians may be able to work together with sister partners to conduct clinical research for addiction and mental health if our Teams structure research together. The research can be published. The emphasis is to reduce ED visits and have significant cost savings while improving patient care and Quality of Life (QoL)Hepatitis C care is offered at Wellbeings.</p>
<p>Wesley Urban Ministries strives to empower low-income vulnerable individuals to find and sustain stable housing and related health benefits. Central to this approach has been the Wesley Street Health Clinic to provide integrated health care access to a high needs, vulnerable population characterized by poverty and additions, that is often denied access to primary care due to their lifestyles. Improved health outcomes amongst this population are supported by a housing first program and a day centre outreach and meal program. The Claremont Special Care Unit is a stable, managed alcohol living environment for 15 alcohol dependent homeless men. Managed alcohol empowers individuals to improve the management of health conditions associated with past homeless and alcohol dependency and allows many individuals to transition away from the street and rebuild their lives. A collaborative partnership with the Shelter Health Network enables the program to provide primary health care to all residents. We are heavily invested in providing supports to parents, caregivers and children, prenatal to 21 years of age. Programs and supports provided include education, early intervention and prevention as well as crisis management. One of our unique programs is the Resettlement Assistance Program,</p>	

<p>this program services and supports government assisted refugees. The supports include housing, health and case management. Another population we serve is older adults. Wesley Urban Ministries provide various supports to older adult's house in the City housing apartment complexes located on Part Street and Sanford Avenue North. We feel the supports provided to individuals in these buildings support independent living as well as connects older adults to much needed supports in the community. In all instances we work alongside many community partners to ensure services are accessible, coordinated, integrated and efficient.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>Wesley programs have expertise in working with the low-income population in Hamilton that is without shelter (homeless) and/or vulnerably housed and live with mental illness and addictions. Our intensive case management housing first program has years of experience helping individuals to establish stable housing in the community, manage health care issues, addictions and mental illness. The Wesley Street Health Clinic could be a diverter from ER and connector to primary health care for a high needs population. The profile of individuals who come to the Claremont Special Care Unit fit into the high users profile with the added complexity that they are alcohol dependent. A recent individual admitted to the program was costing up to \$3,000 per day in a hospital setting versus the \$140 per day of the Claremont program. 2013 presents an opportunity to expand the current Claremont program at a new site within the Central Hamilton area. This can also provide opportunities for integration and collaboration with other programs.</p>	<p>Current facilities and some operating expenses. Health care, program professionals and program expertise.</p>
<p>YMCA of Hamilton/Burlington/Brantford is a powerful association of people of all ages and from all walks of life joined together by a shared passion: to strengthen the foundations of community. As one of the largest charitable community service organizations in Canada, the YMCA responds to critical social needs in the community. With a commitment to nurturing the potential of children, teens and young adults, promoting healthy living, and fostering social responsibility, the YMCA ensures that every individual has access to the essentials needed to learn, grow and thrive. Serving more than 200,000 individuals throughout Hamilton, Burlington and Brantford, the YMCA of Hamilton/Burlington/Brantford provides vital services such as health, fitness and recreation, child care, camping, outdoor education, immigrant settlement services, employment, education, leadership development and volunteerism. The YMCA connects people to life-building opportunities, to each other and enhances their quality of life.</p>	
<p>What will your contribution be</p>	<p>What resources will you be able to contribute in-kind</p>
<p>The YMCA is involved in a community health partnership called Live Well with Hamilton Health Sciences and McMaster University. Our support would be in community based health programs that support a strong continuum of care.</p>	<p>Human capital in strategic leadership and current program delivery.</p>
<p>YWCA Hamilton provides transitional housing for women who are homeless, senior centres, developmental services, Health and Wellness Programs (breast cancer, bone issues, heart, etc.) and children's services and licensed child care.</p>	

4.2 Support the MOHLTC or Other Entities Could Provide

We look to the Ministry to help refine the measurement of metric indicators, support on privacy and IT development, providing data, communications expertise, and funding to complete a LHIN-wide information systems integration strategy.

We also look to the Ministry for receptiveness and responsiveness to our requests for system and policy changes in the service of health system transformation.

The HNHB LHIN offers an opportunity to leverage an incremental investment in an Integrated Point of Care Information System (IPOC-IS) to enable support of Health Link transformation strategies beyond Hamilton Central to the entire LHIN. Building on a strong foundation of IT collaboration across the LHIN and the system connectivity achieved to date, LHIN-wide integration is a realistic objective by the end of 2014. Given the work of HCHL – and the integrated information system required to support that work – encompasses key hospital and community-based systems in the LHIN, to create the required IT infrastructure for HCHL alone represents 65-70% of the estimated cost of creating it to serve the full LHIN. The HCHL budget is able to contribute its proportion of this LHIN-wide cost based on population served (10%), however, will be unable to deliver the intended results for HCHL if it has to bear the full cost of connecting required systems as part of the early adopter program. Given LHIN-wide integration is within reach in a community characterized by early adoption of, and leadership in, innovative health technologies, the Ministry has the opportunity to create a rich demonstration and evaluation site for its vision of fully connected communities. Specifically, an advance investment now in the IT infrastructure for the remaining Health Links in the LHIN will accelerate the work of HCHL and that of subsequent Health Links, enabled by a fully integrated Point of Care Information System (see Potential IPOC-IS diagram in Section 2.2.4). Further, given the technologies that will be connected within the HNHB LHIN are present in adjacent LHINs, this investment will yield accelerator dividends beyond LHIN boundaries, better supporting care that transcends geographic lines (e.g. specialty pediatric care) and moving the province forward in its overall eHealth vision for 2015.

4.3 Initial Sustainability Plan

Expectation of cost recovery: There is a substantial literature that points to decreased cost through improved quality. We do expect that our quality improvement process will improve care for those who use care the most, decrease hospital utilization, and thus decrease costs to hospitals. However, since our focus is not on all patients who use hospital services, but rather on a specific sub-population, we can only be certain of the decrease in cost attributed to this specific population. For example, if we see a 25% decrease in hospital use among the top 5% cohort, then we will have a 25% reduction in hospital-related costs for this population. But it is also possible that this will decrease ER wait times enough that more people from other parts of the population will find it more favourable to start using ER and so costs to the system will not decrease. We also know that in decreasing ER use we will likely increase primary care and CCAC use, though hopefully not as much. We also know that many other factors could lead to overall increase in hospital use (epidemic, public advertising for new urgent care site, retiring family physicians). If there are in fact decreases in hospital-related costs, then we suggest that "reinvestment in other Health Links initiatives (HL BP guide)" is something that HCHL could suggest, but that the ultimate decisions on this matter would be the responsibility of the respective service providers, the HNHB LHIN and the MOHLTC. In short, we do not expect in this one year of work to be able to show cost savings substantial enough to re-invest in other areas, and we do not expect HCHL (which is not an entity) to make these decisions. What will be most important is for us to measure throughout the first year all utilization costs attributed to this population, as well as to the general population, in order to describe where there have been increases and where there have been decreases so that re-investment decisions may be made with the best evidence to support those. In short, we will need to "take account". Where we expect to see our greatest savings is in elimination of redundancy, that is, that through the focused efforts of all organizations on the single aim of decreased hospital utilization, we have already begun to recognize where overlapping mandates are not helpful, and to seek ways to change those. In

order to be able to report cost savings, these kinds of changes will be noted and cost savings attributed.

Human resource realignment and succession planning from the start: The leadership team for the first year of work is drawn primarily from McMaster Department of Family Medicine/Family Health Team.

However, what we have already seen in our first 8 weeks of operation, and expect to see much more, is partner organizations re-aligning their own services and staff responsibilities to undertake the work of serving the stated aims. Many staff hours have already been contributed, many more changes are being planned, and some programs and staff have already been realigned at the level of LHIN, hospitals, CCAC and community services. McMaster DFM/FHT has every intention to continue to work in its current role, as long as that is the wish of the LHIN and the MOHLTC. But we will also be working to ensure that the understanding of this model and the expertise that could support it into the future is broadly based and well established.

Expectation of non-permanence: One of the reasons the health system is in difficulty currently is that solutions that were developed for problems long ago are still in place. Any expectation of longevity for solutions that we develop through Health Links will, paradoxically, render the relevance and impact of those same solutions null very quickly. Thus, we enter this endeavor with an expectation of non-permanence, and attention to what will need to change continually. We expect that the solution we are proposing in this document today will need to be retired at the end of a year (or earlier) for an even better solution.

Investment in the anchoring principle of relationship: What will sustain ongoing transformation is excellent relationships between service providers and patients, among services providers and each other, between service providing agencies, and between agencies and funders. Because of our guiding philosophy that the engine for transformation grows out of the quality of these relationships, our first year of work will place a constant emphasis on the quality of all of these relationships, with the hope that this could carry transformative power into whatever new technique, program or service that is imagined over time.

Investment in the anchoring principle of continuous learning: Our Learning Circle method will be something not yet experienced by our coalition. It will allow for intensive study and quality improvement to become part of everyday work. If our first year of work is done well, it should be apparent to all involved that it has produced value worth continuing to invest in.

5.0 Governance & Administration

5.1 Governance

Hamilton Central Health Link

The HCHL Link consists of all partners, decision makers and knowledge users. It will meet annually to report on and integrate findings and assist with knowledge translation and exchange activities. The Annual Meeting will be face-to-face/webinar.

MOHLTC

The Ministry of Health and Long Term Care has commissioned the HNHB LHIN to ensure that the HCHL mandate is carried out. MOHLTC will support the LHIN and HCHL through a variety of province-wide activities, will provide funding for the first year of HCHL operations, and will receive reports from the LHIN about the progress of HCHL.

HNHB LHIN

The HNHB LHIN has received a mandate from the MOHLTC to carry out the Health Links initiative. It will provide strategic guidance to the HCHL team, will support it through expertise in data analysis and communications, and will receive reports from the HCHL advisory board about the progress of the work of the HCHL team.

Advisory Board

The **Advisory Board** includes David Price (Board chair, and Chair of the Department of Family Medicine), David Higgins, (President of St. Joseph's Healthcare Hamilton), Brenda Flaherty (Exec. V.P. and Operating Officer, Regional Services), Terry McCarthy (Executive Directory, Hamilton Family Health Team), Paul Johnson (Director of Neighbourhood Development Strategies), Melody Miles (CEO, HNHB CCAC), Elizabeth Richardson (Medical Officer of Health, City of Hamilton Public Health), Dale Guenter (Associate Professor Department of Family Medicine), Anne Childs (FHT Coordinator, McMaster Family Health Team), Tracey Carr (Director of Administration, McMaster Department of Family Medicine), Donna Cripps (CEO, HNHB LHIN). The members of this board are responsible to ensure the commitment of their teams to the HCHL, provide input to the initiatives and provide agreement on the initiatives of the HCHL. Agreement may be received via face-to-face meetings, teleconference or email. The Advisory Board will meet at least twice a year and will be directly accountable to the HNHB LHIN.

Lead Team

The **Lead Team** includes members from the Department of Family Medicine/McMaster Family Health Team and the HNHB LHIN and may also expand in time to include key people from key organizations. This group will be responsible for overall planning, implementation and monitoring of the HCHL (e.g. knowing what the various programs are at different care points, talking to system support clusters to obtain counsel, plan and monitor timelines and budgets), taking system change ideas that surface from the Learning Circle to the clusters or leaders for change, facilitate quality improvement projects of current programs and resolve challenges arising in the conduct of HCHL. Leading Members of the Lead Team include:

HCHL Executive Lead: David Price, MD, CCFP, FCFP – Dr. Price is Professor and Chair of the Department of Family Medicine at McMaster University, and Chief of Family Medicine at Hamilton Health Sciences. Dr. Price has been a family physician for over 25 years, practicing comprehensive family medicine. He is the founding Director of the inter-professional Maternity Centre of Hamilton, and was instrumental in helping to create the academic Family Health Team at McMaster University which currently serves over 29,000 patients in the Hamilton area. Dr. Price helped lead the development of OSCAR and MyOSCAR and has held a number of research grants looking at quality improvement in family practice.

HCHL Lead: Dale Guenter MD, MPH, FCFP--family physician with training and experience in public health, determinants of health, health services administration and research, inner city health, quality improvement and community-based research. Dr. Guenter has extensive involvement in community-based action for health improvement from the primary care and HIC care perspectives. He is co-director of McMaster Family Practice at McMaster Family Health Team, associate professor in Department of Family Medicine, co-founder and board member of the Shelter Health Network. He will provide overall operations leadership to HCHL.

HCHL Co-Lead/Group process Coordinator: Dr. Cathy Risdon is the Associate Chair, (Academic) in the McMaster Department of Family Medicine, The Co-Lead of the McMaster Family Health Team and the Co-Director of McMaster Family Practice. She has a Doctorate of Management in Organizational Change (University of Hertfordshire) and has consulted internationally on relationship centred administration, inter professional collaboration and team functioning. She will provide facilitation to the Learning Circle.

HCHL Co-Lead, System Integration and IT: Tracey Carr, RN, BScN, MBA – Registered Nurse with expertise in Health Services Management and a career spanning primary care, public health, implementation of a provincial strategy for system change related to organ and tissue donation, and strategic and operational leadership in a variety of contexts. In her current role as Director, Department of Family Medicine at McMaster, Tracey has extended her leadership influence in the area of ehealth innovation and has been instrumental in strengthening the governance, operations and strategic development of OSCAR and MyOSCAR.

HCHL Co-Lead, System Integration and IT: Anne Childs, RN, BScN, Ms(N)– Registered Nurse with over 30 experience within the hospital, community and primary care sectors. In her current role as the Co-Lead and Coordinator of the McMaster Family Health Team with the Department of Family Medicine, she works closely with the leadership team of the DFM, and is responsible for the funding and staffing of the Family Health Team. She currently serves on the executive committee of the Department of Family Medicine and the board of directors of the Shelter health network. She is an integral part of the leadership within each of the clinical teaching units associated with the FHT.

5.2 Administration

The signatory to the Health Links accountability agreement is David Price, Chair, McMaster Department of Family Medicine/McMaster Family Health Team.

6.0 Signatories

The following collaborating partners approved the Business Plan.

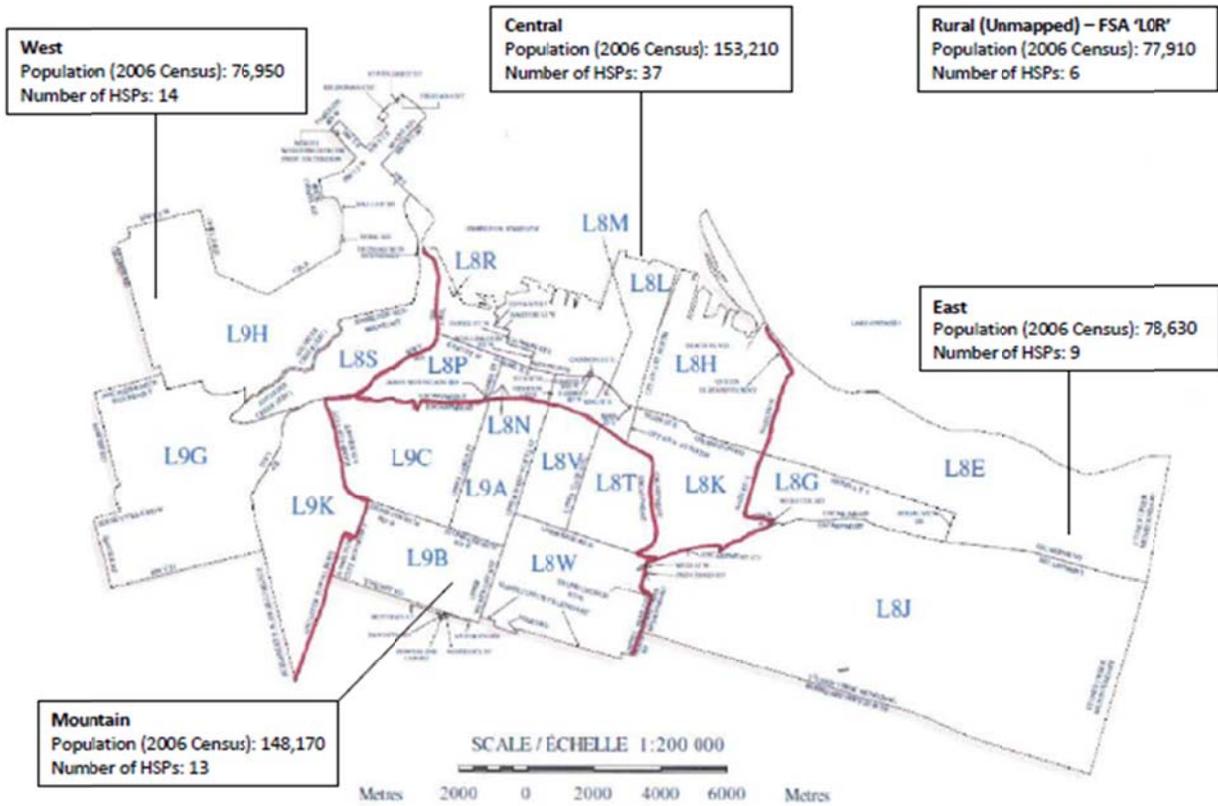
Name & Signature	Organization & Date Signed
Brenda Flaherty	Hamilton Health Sciences
David Higgins	St. Joseph's Healthcare Hamilton
Barb Busing	HNHB Community Care Access Centre
Paul Johnson	City of Hamilton
Elizabeth Richardson	City of Hamilton – Public Health
Steve Sherrer	AbleLiving Services/St. Peter's Residence Chedoke
Sue Kennedy	Alternatives for Youth
Jan Narduzzi	Brain Injury Services
Marilyn Jewell	Canadian Mental Health Association (CMHA), Hamilton Branch
Marcel Castonguay	Centre De Santé Communautaire Hamilton-Niagara
Constance McNight	De dwa dehs nye's Aboriginal Health Centre
Katharine Kalinowski	Good Shepherd
Terry McCarthy	Hamilton Family Health Team
Gord Hirano	Hamilton Program for Schizophrenia
Denise Brooks	Hamilton Urban Core Community Health Centre
Elizabeth Beader	North Hamilton Community Health Centre
Trish Balardo	Seniors Activation Maintenance (SAM) Program
Zahira Khalid	Shelter Health Network
Liz Froese	Southern Network of Specialized Care
Leonora Regenstreif	The Hamilton Clinic
Genevieve Hladysch	The YMCA of Hamilton/Burlington/Brantford
Irene Pasel	VON Canada – Ontario Branch
Regan E. Anderson	Wayside House of Hamilton
Peggi DeGroot	Wellbeings Pain Management and Dependency Clinic Inc.
Dean Waterfield	Wesley Urban Ministries
Medora Uppal	YWCA Hamilton

APPENDIX A: HCHL Team

Organization/Department	Name	Role
Alternatives for Youth	Sue Kennedy	Executive Director
Brain Injury Services	Jan Narduzzi	Executive Director
Canadian Mental Health Association (CMHA), Hamilton Branch	Marilyn Jewell	Executive Director
Canadian Mental Health Association (CMHA), Hamilton Branch	Margaret Foley	
Canadian Mental Health Association (CMHA), Hamilton Branch	Kathryn Lanza	
Centre De Sante Communautaire Hamilton-Niagara	Marcel Castonguay	Executive Director
Centre De Sante Communautaire Hamilton-Niagara	France Vaillancourt	Assistant Executive Director
City of Hamilton	Paul Johnson	Director of Neighborhood Development Strategies
City of Hamilton - Public Health	Elizabeth Richardson	Medical Officer of Health
City of Hamilton - Public Health	Glenda McArthur	Director Clinical & Preventive Services
City of Hamilton - Paramedic Services	Brent Browlett	Chief Paramedic Services
City of Hamilton - Housing Services	Brian Kreps	Manager, Residential Care Facilities and Emergency Shelter Services
De dwa dehs nye's Aboriginal Health Centre	Constance McKnight	Executive Director
Good Shepherd, Hamilton	Katherine Kalinowski	Assistant Executive Director, Programs
Good Shepherd, Hamilton	Brother Richard MacPhee	Executive Director
Good Shepherd, Hamilton - CORE	Cole Gately	Clinical Director
Hamilton Family Health Team	Terry McCarthy	Executive Director
Hamilton Family Health Team	Catherine McPherson-Doe	Mental Health Program Manager
Hamilton Health Sciences	Brenda Flaherty	Exec. V.P. and Chief Operating Officer, Regional Services
Hamilton Health Sciences	Wendy Gerrie	Director Decision Support Services HHS and IDS Lead
HNHB Community Care Access Centre	Melody Miles	CEO
HNHB Community Care Access Centre	Barb Busing	VP, Clinical Operations
HNHB Community Care Access Centre	Tom Pierce	VP, Strategy, Quality & Performance Management
HNHB Community Care Access Centre	Janet Noble	Director, Client Services
Hamilton Program for Schizophrenia	Gord Hirano	Clinical Director
Hamilton Urban Core Community Health Centre	Denise Brooks	Executive Director
Hamilton Urban Core Community Health Centre SAM Program (Seniors Activation Maintenance Program)	Vikas Sood	Information Systems Analyst
Shelter Health Network	Trish Balardo	Executive Director
Shelter Health Network	Zahira Khalid	Medical Directory Shelter Health Network
Shelter Health Network	Myles Sergeant	

Organization/Department	Name	Role
Southern Network of Specialized Care	Liz Froese	Coordinator
Southern Network of Specialized Care	Tom Archer	Health Care Facilitator
St. Joseph's Healthcare Hamilton	David Higgins	President
St. Joseph's Healthcare Hamilton	Jane Loncke	Director Clinical Programs
The Hamilton Clinic	Dr. Leonora (Lori) Regenstreif	Medical Lead MD
McMaster Family Health Team/Department of Family Medicine	David Price	Chair
McMaster Family Health Team	Dale Guenter	co-director at McMaster Family Practice
McMaster Family Health Team	Anne Childs	FHT Coordinator
McMaster Family Health Team	Cathy Risdon	Assistant Chair
McMaster University Department of Family Medicine	Tracey Carr	Director
North Hamilton Community Centre	Elizabeth Beader	Chief Executive Officer
The YMCA of Hamilton/Burlington/Brantford	Genevieve Hladysch	Senior Regional Manager
VON Canada - Ontario Branch	Irene Pasel	District Executive Director
VON Canada - Ontario Branch	Sherri Huckstep	Regional VP Community Support Services
Wayside House of Hamilton	Regan E. Anderson	Executive Director
Wesley Urban Ministries	Dean Waterfield	Director of Housing and Homelessness
Wesley Urban Ministries	Daljit Garry	
Wellbeings Pain Management and Dependency Clinic Inc.	Peggi DeGroote	Founder and President
Wellbeings Pain Management and Dependency Clinic Inc.	Martha Ross	Director, CFO
YWCA Hamilton	Medora Uppal	Directory of Operations

APPENDIX B: Map of Hamilton Central Health Link Catchment Area



APPENDIX C: Health Link Indicator Definitions

	Aim	Measure
	<i>Operational Metric</i>	
1	<i>Increase the number of complex and senior patients with regular and timely access to a primary care provider.</i>	Within Top 5% Cohort, percent attached to family physician, last attendance, problems with access. CCAC will assess through interview and short access questionnaire to be developed. Compare month 1 to month 10.
2	<i>Ensure the development of coordinated care plans for all complex patients</i>	Within Top 5% Cohort, percent that have care plan in place per CCAC records.
	<i>Results Based Metric</i>	
1	<i>Reduce the time from primary care referral to specialist consultation for complex patients.</i>	TBD
2	<i>Reduce the number of 30 day readmissions to hospital.</i>	Within Top 5% cohort, and in general population, number of readmissions within 30 days, from Discharge Abstract Database or IDS
3	<i>Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere.</i>	Within Top 5% Cohort, and in general population, number of CTAS 4,5 ER visits per capita, from National Ambulatory Care Reporting System or IDS.
4	<i>Reduce time from referral to home care visit for patients.</i>	90th and 50th percentile wait time for home care services (application to first service) for community and hospital settings, by client type (all, short stay acute, short stay rehab, long-stay complex), from home care database
5	<i>Reduce unnecessary admissions to hospitals</i>	Within Top 5% cohort, and in general population, number of ambulatory care sensitive conditions per capita, from Discharge Abstract Database or IDS
6	<i>Ensure primary care follow-up within 7 days of discharge from an acute care setting</i>	Within Top 5%, and general populations, proportion of discharges with physician visits within 7 days of discharge, from Discharge Abstract Database and Claims History Database.
	<i>Evaluation Based Metrics</i>	
1	<i>Reduce the average cost of delivering health services to patients without compromising the quality of care.</i>	TBD
2	<i>Achieve an ALC rate of 9 per cent or less</i>	Among general population, percent alternate level of care days, from Discharge Abstract Database.
3	<i>Enhance the health system experience for patients with the greatest health care needs</i>	Enhance the Health System Experience for Patients with Greatest Health Care Needs.

APPENDIX E: Work Plan

HCHL Work Plan	2012			2013												2014		
	Dec	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March		
Develop Business Plan (included over 25 meetings with individuals and organizations including 2 large (45 +) partner meetings, 1 Advisory Board meeting and weekly Lead Team meetings)	█	█	█															
Hire additional core staff (Social Animator, QI Coach, Admin Assistant)				█	█													
Develop care planning process				█	█													
Learning Circle weekly Initial Meetings and Development - Smaller Group				█	█													
Learning Circle Regular Weekly Sessions						█	█	█	█	█	█	█	█	█	█	█		
Care plan initiated for top 5%				█	█	█	█											
1st experiment Designed and Implemented						█												
Gathering Patient and Provider Stories							█	█	█	█	█	█	█	█	█	█		
Patient/family engagement (4 meetings)							█	█	█	█				█	█			
Information Technology Solution																		
IT requirements definition				█	█	█												
IT solution procurement and Implementation							█	█	█	█	█	█	█	█	█	█		
Website																		
Develop initial website			█															
Continual updating of website (e.g. patient stories, adding video summaries, training, continuing the blog and twitter, updating partners, updates, communication pieces)				█	█	█	█	█	█	█	█	█	█	█	█	█		
Evaluation																		
Report on Primary and Secondary Aims							█			█			█			█		
Report on social change occurring in health system							█			█			█			█		
Meetings																		
Advisory Board							█				█					█		
Partner Meeting							█			█			█			█		

APPENDIX F: Table of Acronyms

Acronym	Meaning
HCHL	Hamilton Central Health Link
CCAC	Community Care Access Centre
CHC	Community Healthcare Centre
SJHC	St. Joseph's Healthcare Hamilton
HHS	Hamilton Health Sciences
ED	Emergency Department
UCC	Urgent Care Centre
DFM	Department of Family Medicine
FHT	Family Health Team
COPD	Chronic Obstructive Pulmonary Disease
HNHB	Hamilton Niagara Haldimand Brant
LHIN	Local Health Integration Network
IT	Information Technology
QI	Quality Improvement
MD	Medical Doctor
EMR	Electronic Medical Record
BP	Blood Pressure
HIC	Health Information Custodian
PHIPA	Personal Health Information Protection Act
IDS	Integrated Decision Support
NP	Nurse Practitioner
IBD	Inflammatory Bowel Disease
TIA	Transient Ischemic Attack
LTC	Long-term Care
MOHLTC	Ministry of Health and Long-term Care
BSO	Behavioural Support Ontario

APPENDIX G: References

(1) Greenhalgh T., Hurwitz B. Why study narrative? *BMJ* 1999;318:48-50.

Hamilton Central Health Link

Responses to Ministry Feedback on Business Plan

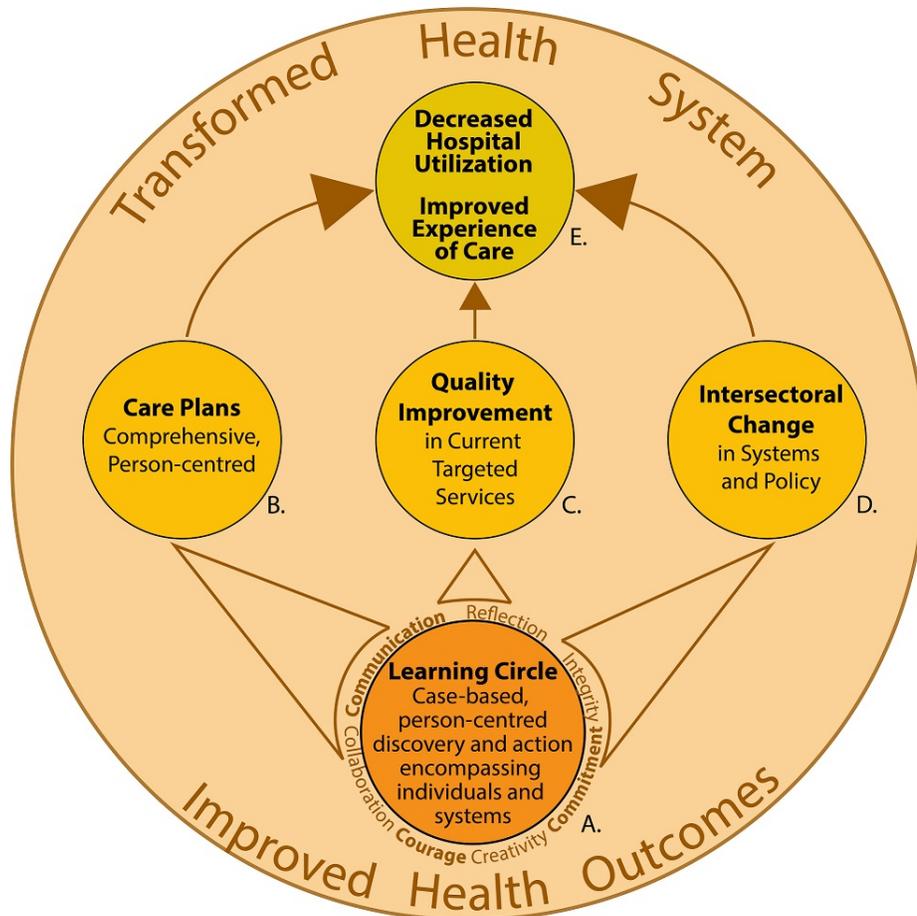


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1. Summary of Feedback from the MOHLTC

The Ministry of Health and Long-Term Care (MOHLTC) provided the following feedback from the Hamilton Central Health Link Business Plan that was submitted in February 2013.

a. Areas of strength

- The Business Plan showed a solid understanding of the complex patient cohort, the social and health conditions affecting them as well as health care utilization patterns. This population health based planning is inherent to the Health Links model and there is clearly progress that has been made on this.
- The measures of success have been identified (e.g. care plans for everyone in the 5% cohort, attachment to primary care provider); however, no timelines are provided. Specific targets and timelines for those targets (e.g. x number coordinated care plans in place for y number of patients by March 2014) is where we need to get to with this
- Patient engagement and the use of patient stories factors strongly in the business plan, which is excellent.
- Unique model is presented.

b. Areas needing improvement

- The measures of success have been identified (e.g. care plans for everyone in the 5% cohort, attachment to primary care provider, etc); however, no timelines are provided. Specific targets and timelines for those targets (e.g. x number coordinated care plans in place for y number of patients by March 2014) is where we need to get to with this.
- Signatures representing partner endorsement are absent from business plan. Partner endorsement is needed
- How initiatives will be practically sustained is not clear.
- The budget is quite heavy on the administrative leadership and leadership aspects (over 50% of the budget). This makes it difficult to clearly delineate the concrete deliverables that will result from the investment. Business Plans that were stronger in this area included a resource plan that directly matched concrete commitments (e.g having a certain number of care plans in place for a certain % of the cohort by a certain date). The Business Plan, including the resource plan, could benefit from improvement through this lens.
- Overall, the business plan appears heavy on planning versus implementation. An additional focus on the latter would better demonstrate how these initiatives will improve care for patients at a lower cost.

2. Outcomes and Metrics

HCHL has developed deliverables and mapped those to the MOHLTC operational metrics. We have re-prioritized the 11 MOHLTC metrics to suit our own way of thinking about the work to be done. (This essentially reflects our differing opinion about what are “operational, results-based and evaluation” metrics.) To do this, we have identified which metrics are, for us, “mission/aspiration” statements. These are characteristics of a transformed health system, goals so lofty they are difficult to define and to measure, but vitally important to keep front and centre. Our two Mission/aspiration metrics are: *Reduce the average cost of delivering health services to patients without compromising the quality of care [EBM1]. Enhance the health system experience for patients with the greatest health care needs [EBM3].*

Then we have defined “primary aims”. To us, a primary aim is a readily measurable, succinct change. There is general agreement that it has relevance and value in achieving the mission/aspiration. A primary aim is big enough to suggest a variety of specific actions, interventions, programs or policies that would serve to achieve the aim. Our two primary aims are: *Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere [RBM3]. Reduce unnecessary admissions to hospitals [RBM5].*

We have defined “secondary aims” as metrics for which there may be less ready agreement about relevance or value, where it is not as clear that these will steer us toward the mission/aspiration, where the activity suggested by the metric may be more narrow, or where the measurement of outcome still has not been developed and may be difficult to do so. Many of the secondary aims are what will be used to achieve the primary aims, some are ready to be worked on, others will need effort to develop. Our secondary aims include: *Increase the number of complex and senior patients with regular and timely access to a primary care provider [OM1]. Ensure the development of coordinated care plans for all complex patients [OM2]. Reduce the time from primary care referral to specialist consultation for complex patients [RM1]. Reduce the number of 30-day readmissions to hospital [RM2]. Reduce time from referral to home care visit for patients [RM4]. Ensure primary care follow-up within 7 days of discharge from an acute care setting [RM6].*

We have defined one “tertiary aim”, which has little relevance to the primary aims, though it is certainly relevant to the mission/aspiration. Working on the tertiary aim will not serve the primary aims, and will require activities and programs that are quite different. This will have the lowest priority for our work plan. Our tertiary aim is: *Achieve an ALC rate of 9 per cent or less [EM2].*

Our intent is to keep a firm focus on the primary aims, to be active in improving most of the secondary aims, and to place the least attention and action on the tertiary aim.

Table 1: Outcomes and Measures

MOHTLC	HCHL Declared Deliverables	Measures/Indicators
Operational Metric		
<p><i>1. Increase the number of complex and senior patients with regular and timely access to a primary care provider. This is an HCHL secondary aim.</i></p>	<p>A. By March 31 2014: Among the top 5% cohort all who do not have family physician will have been through a problem-solving process to get one, led by CCAC’s Health Care Connect.</p> <p>B. By March 31 2014: A system-level solution (including funding, policy) for improving access to primary care for complex patients will have been developed.</p>	<p>Within Top 5% Cohort, percent attached to family physician by self-report, last attendance, problems with access, measured by CCAC with brief access assessment.</p>

<p>2. Ensure the development of coordinated care plans for all complex patients. This is an HCHL secondary aim.</p>	<p>C. By March 31 2014: All of our top 5% cohort will have been through review and care planning process involving formal and informal circle of care, led by CCAC. With those for whom care planning is deemed impossible, reasons for this will be described.</p> <p>D. By July 1 2013: We will have in place a process for identifying people who are at risk of becoming high utilizers of health services and will be ready to implement this process to address high utilization at the earliest point.</p>	<p>Common care planning process developed and agreed to by all sectors.</p> <p>Within Top 5% Cohort, percent that have care plan in place per CCAC records.</p>
<p>Results Based Metric</p>		
<p>1. Reduce the time from primary care referral to specialist consultation for complex patients. This is an HCHL secondary aim.</p>	<p>E. By March 31 2014: Among the top 5% cohort, system barriers to specialist referral will have been identified, the current Rapid Assessment Clinic model (Internal Medicine, Psychiatry) will be expanded and enhanced for better access by primary care.</p>	<p>TBD by August 1 2013</p>
<p>2. Reduce the number of 30 day readmissions to hospital. This is an HCHL secondary aim.</p>	<p>F. For calendar year 2013: Among top 5% cohort number of admissions within 30 days to be less than for calendar year 2012, using all interventions in this table.</p>	<p>Within Top 5% cohort, and in general population, number of readmissions within 30 days, from Discharge Abstract Database or IDS</p>
<p>3. Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere. This is HCHL Primary Aim. </p>	<p>G. For calendar year 2013: For top 5% cohort, decrease number of ED visits by 10% overall, when compared with calendar year 2012. Achieve this through Learning Circle interventions, policy change, and all of the other metrics in this table.</p>	<p>Within Top 5% Cohort, and in general population, number of ER visits per capita, from National Ambulatory Care Reporting System or IDS.</p>
<p>4. Reduce time from referral to home care visit for patients. This is an HCHL secondary aim.</p>	<p>H. For calendar year 2013: For all CCAC referrals made within HCHL population, demonstrate a decrease in time from referral to visit, when comparing 2013 to 2012.</p>	<p>90th and 50th percentile wait time for home care services (application to first service) for community and hospital settings, by client type (all, short stay acute, short stay rehab, long-stay complex), from home care database</p>
<p>5. Reduce unnecessary admissions to hospitals. This is an HCHL primary aim. </p>	<p>I. For calendar year 2013: For top 5% cohort, decrease number hospital admissions by 10% overall, when compared with calendar year 2012. Achieve this through Learning Circle interventions and all of the other metrics in this table.</p>	<p>Within Top 5% cohort, and in general population, number of ambulatory care sensitive conditions per capita, from Discharge Abstract Database or IDS</p>
<p>6. Ensure primary care follow-up within 7 days of discharge from an acute care setting. This is an HCHL secondary aim.</p>	<p>J. By October 1 2013: Develop a comprehensive strategy for “meaningful contact” (not necessarily visit) with primary care within 7 days of discharge.</p> <p>K. By October 1 2013: Develop a method for measuring “meaningful contact” within 7 days (may not be able to rely on claims database)</p>	<p>Within Top 5%, and general populations, proportion of discharges with physician visits within 7 days of discharge, from Discharge Abstract Database and Claims History Database.</p>

Evaluation Based Metric		
<p>1. <i>Reduce the average cost of delivering health services to patients without compromising the quality of care. This is an HCHL mission/aspiration statement.</i></p>	<p>L. By October 1 2013: Develop a methodology for calculating health service costs for specific patients.</p> <p>M. By March 31 2014: Measure and report the cost for the top 5% cohort for 2013 compared with 2012.</p>	<p>TBD</p>
<p>2. <i>Achieve an ALC rate of 9 per cent or less. This is an HCHL tertiary aim.</i></p>	<p>N. By March 31 2014: Demonstrate a decrease in ALC for all Hamilton hospitals from 13% average for 2012 to 11% for 2013.</p>	<p>Among general population, percent alternate level of care bed days, from Discharge Abstract Database.</p>
<p>3. <i>Enhance the health system experience for patients with the greatest health care needs. This is an HCHL mission/aspiration statement.</i></p>	<p>O. By October 1 2013: Work with MOHLTC to develop a tool to measure health system experience.</p> <p>P. By March 31 2014: Implement the tool in the top 5% cohort to determine whether health system experience has improved over 1 year.</p> <p>Q. By July 1 2013. A plan in place for moving through the continuum of patient engagement to where there is involvement in planning of HCHL initiatives.</p> <p>R. By December 31 2013: At least 6 “drill deep” patient stories to be reviewed by learning circle. 10 patient stories will have been documented in print, video or voice, and will be widely disseminated within the health system and the public domain. Patients will be involved in planning HCHL initiatives.</p>	<p>TBD.</p> <p>Learning circle participants document “events of cognitive shift” where patient story details contribute to novel inspiration and innovation.</p>
<p>Other HCHL deliverables that apply generally to all of the above</p>		
	<p>S. By March 2013: Initiate Learning Circle methodology to carry out patient-centred, experience-based review of current programs and policies that impact metrics in this table, understand how these need to be improved, initiate inter-sectoral action for improvement, and measure impact of these improvements.</p>	<p>Log of improvements in inter-sectoral relationships, shifts in understanding of problems and solutions, actions taken, success in improving policies and programs.</p>
	<p>T. By March 31 2014: We will understand what the requirements are for IPOC-IS and subject to confirmation of funding in a timely manner will substantially implement in year 1.</p>	<p>Plan in place for implementing IPOC-IS.</p>

3. Current Programs and Relevant Metrics

Table 2 provides a summary of some of the core organizations involved in the Hamilton Central Health Link, their programs and which MOHLTC metrics are relevant to the program. There are many more and we will continue to map these, but what is clear is that we do not need more programs or innovative services, we just need to be sure these all have maximum impact.

Table 2: Current Programs and Relevant Metrics

Organization/Program	Relevant MOHLTC Metrics
Community Care Access Centre (CCAC)	
Care Coordination	RBM 2, RBM 5
Care Coordination in Family Health Teams	OM 2.
Rapid Response Transitional Team	RBM 4. RBM 6. RBM 2.
Palliative Nurse Practitioner	RBM 3. RBM 5.
Health Care Connectors	OM 1
Hamilton Health Sciences (HHS)	
General Internal Medicine Rapid Access Outpatient Clinic	RBM 1, RBM 5, RBM3
Reducing Emergency Department visits from Long-Term Care	RBM 2. RBM 3.
Optimizing Care for Frequent Users of Emergency Departments in Hamilton	RBM 2. RBM 3. RBM 5. OM 2.
HNHB LHIN Discharge Transition Bundle Project (COPD)	RBM 5. RBM 2.
Improving an already extensive IT and Decision Support Technology	EBM 3.
St. Joseph's Health Care Hamilton (SJHC)	
Internal Medicine Rapid Assessment Clinic	RBM 1, RBM 5, RBM3
Firestone Urgent Assessment Clinic	RBM 1, RBM 5, RBM3
Diabetes Clinics	RBM 1, RBM 5, RBM3
Community Psychiatry Program	RBM 1, RBM 5, RBM3
Crisis Outreach and Support Team (COAST)	RBM 1, RBM 5, RBM3
Assertive Community Resource Team	RBM 1, RBM 5, RBM3
Cleghorn Early Intervention in Psychosis Program	RBM 1, RBM 5, RBM3
Integrated Comprehensive Care – Bundle Care Project (COPD, CHF)	RBM 5. RBM 2.
Optimizing Care for Frequent Users of Emergency Departments in Hamilton	RBM 2. RBM 3. RBM 5. OM 2
City of Hamilton	
Public Health Services	RBM 3
Hamilton Paramedic Services CREMS program and CHAP EMS (EMS health promotion programs to avoid ED visits)	RBM 3.
Neighbourhood Development Strategy (Neighbourhood input on health service coordination)	EBM 3.

4. Planning, Implementation, Sustainability, Resources and Deliverables

We are responding to the MOHLTC request for clarification about what we are doing that is planning and what is implementation, what our sustainability plan is, and how the budgeted resources connect to the deliverables

To begin, we will describe what has taken place to date.

- 25 organizations have signed on, agreeing to bring their programs and services to the group for scrutiny about impact, study of opportunities, clarification of organization roles,

- improved ways of doing work together, identifying barriers of organizational culture and of logistics, and de-bunking false assumptions about organizations.
- 8 new organizations have asked to join the movement since the business plan was submitted and they are being brought on board (including police, housing programs, long term care sites, homecare nursing companies)
 - At least 4 organizations (including health and community) are working on a plan to commit large contributions of staff time (from 0.2 to 1 FTE) to be involved in the work of HCHL, with the faith that the work being done is important to the entire city and to civil society in general. There is a clear sense that this effort and collaboration are what might make our city a healthier place to be.
 - The Learning Circle has been convened for two sessions in which a single patient journey from the top 5% cohort has been described (anonymously), discussed, analysed for themes and system leverage points, and given rise to action for the health system. Each of these sessions has included most of the circle of care as well as key leaders from organizations relevant to the system barriers that this case illuminates, in total about 15 people. The learning circle has committed to meeting every 2 weeks at this point.
 - The learning circle has flagged major barriers, and opportunities, where action could help to achieve our primary aims. Some of these are: plans formed for a first rapid QI experiment; plan to develop a mediation or harm reduction approach to caring for people who receive large amount of service with no interest in behavior change or health improvement; action plan for policy change to the mandated EMS response to transfer all patients to hospital. All of these have the potential to have major impact on hospital and ED utilization. All have arisen from studying just one patient's journey.
 - The learning circle has delved deeply into the challenges that limit our ability to do the good work of inter-sectoral case review and care planning, including privacy legislation, organizational cultures of time management, perceptions of cost related to care planning, and others. Getting past these challenges will transform the health system to work differently, and so we consider it implementation and not planning.
 - Many organizations have already, simply through the awareness that attention is being given to hospital use, begun their own processes of study of patients and clients who are known to have high utilization patterns. This is happening without any direct intervention from HCHL other than to name the priority and begin to provide utilization data on their patients.

We do not expect the Learning Circle to develop or deliver any new services or programs. Rather, we expect it to study intensely a collection of patient journeys, as well as existing programs and services that have any relevance to the stated aims, and through this to:

- Recognize system barriers that need to be addressed through policy or procedural changes, and develop strategy to do this
- Come to agreement for standardizing approaches to activities such as system navigation/case management (of which there is much already happening), hospital-to-primary-care communication, post-hospital follow up, etc.
- Come to agreement on a method for care plan development to be carried out by partner agencies (not by the Health Link itself) and monitor its implementation and impact
- Move beyond inter-organizational myths and assumptions that have restricted effective collaboration and to work more effectively together
- Identify which of the current programs and services are most likely to succeed in achieving the aims, make inter-sectoral recommendations about directing resources toward these programs, and about directing resources away from programs that are not having the intended impact
- Design small experiments to test hypotheses of approaches that could have a high impact on the stated aims

Thus, the learning circle is an engine for transformation. It is both a planning and implementation body, but it will rely on its members to deliver direct service and to continue, adapt, improve or delete programs. This is the work of transformation.

Resources for direct service and programs will all be aligned through the partner organizations that are most appropriate to deliver the specific service.

We have requested resources to support HCHL activities (the detailed description is in the Business Plan). All of these will be aligned with all of the metrics, not with any one metric in particular. With our approach and philosophy we cannot link a specific resource to one specific metric. These include the following:

- Protected time for leadership from within Department of Family Medicine to oversee the work, provide strategic direction, facilitate key relationships and discussion in the community and health sectors, raise awareness of the work, and help organizations to align their work with the HL aims.
- Research methods support (QI coach) to help gather and analyze secondary data to bring to the learning circle to inform its study process, work intensely with partner organizations on quality improvement for key programs or services they provide, help to develop systems for monitoring impact and outcomes
- Social Animator to discover, surface, collect, articulate, document, display and integrate into our work the stories of patients and their caregivers.
- Administrative support to ensure excellent and ongoing planning, communication, and support for all of the partner agencies in order that their participation can take place as easily and effectively as possible

There are already signs of sustainability. A groundswell of agencies are dedicating time and energy to collaboration with their HCHL partners because they believe it will work. This is happening without remuneration, and if the work is valuable, there is every reason to believe that this work, supported by partner agencies, would continue. There has already been some re-allocation of resources within agencies in order to ensure that HCHL work can be done. One participant stated “this is so important, our organization needs to dedicate a person full time to the work so that they can give it their full attention and not be distracted”. Cost saving will be very difficult to demonstrate, but our plan is to try to demonstrate it. If our main objective is to decrease unnecessary hospital utilization, and if we are successful in this, then it will likely mean higher costs in primary care and homecare. However, over time this will also mean greater capacity for hospitals to see more patients and reduce wait times. We expect that it will become evident to the partners that some programs need to be closed down, and that funds will be able to be redirected to where impact is more likely to be higher. We don’t know what programs these are yet, but we will monitor and document these changes. We are not expecting to have another allotment of funds to support the partner organizations in this HL work. We do expect that the only way it will continue beyond our 1 year of funding is if partner organizations see return on investment in the first year and are willing to contribute the necessary resources to keep the work going. The work we will do in the coming year must ultimately be understood not as an additional task on top of all of the other planning and monitoring functions being carried out, but rather a new way of doing the same planning and monitoring that has better impact at lower cost, ultimately flattening the escalating cost curve of health care. If we can prove this to be the case, then the work will be sustained.

HCHL Newsletter

Hamilton Central Health Link



Issue 1—March 2013

HCHL Update

We would like to thank all of our partners for your input, commitment and enthusiasm you provided to develop the HCHL Business Plan. Since our last Partners meeting on February 11, 2013 we have:

- Submitted the Business Plan to the Ministry of Health and Long-Term Care
- Met weekly with the Lead Team to plan the next steps
- Conducted our first Learning Circle session on March 5, 2013 (see Learning Circle under Transformation Plan section in this Newsletter for more details)

WATCH FOR....

- Final version of the Business Plan will be circulated after Ministry of Health and Long-Term Care approval (still awaiting Ministry feedback, our response due by March 20th, 2013).
- The HCHL Website
- Invitation for the next Partners meeting in May 2013

Transformation Plan

Transformation of the health system in our region will be powered by the core methodology of our novel 'Learning Circle', involving person-centred problem solving, engaging all relevant agencies and sectors, improving current services that target high utilization, developing a high impact individual care planning process, conducting small quality improvement experiments for innovation, and promoting broader system and policy changes at all levels. (See diagram page 2)

Invent the Learning Circle (Circle A): What is the Learning Circle?

The Learning Circle is the platform for a series of conversations that will fuel the kind of discovery and commitment needed to transform the health system. Our starting point is a list of the 320 people in the HCHL region who are in the top 5% for being in emergency departments or admitted to hospitals. Since a hospital and CCAC are already in the circle of care for most of these people, and since it is their data that generated this list, those two organizations will help initiate the learning circle process which involves a careful study of the whole context of why each person is using the health system as much as they are. These cases bring to light where in the system we need to make changes and who needs to be involved in the experimentation and innovations to make those changes happen. Although the pilot phase of the Learning Circle has begun with the voices of the Hospitals and CCAC, we will need the expertise and creativity of all our community partners to achieve meaningful impact.

On March 5 we had one test run of this process and in more than an hour we only made it through half of one patient's presentation. And in this time we learned so much! The people around the table for this discussion included administrators and front line workers who were involved with this patient, from CCAC, HHS, SJHH, and Hamilton FHT. We have realized how little we all know about each others' work, about how each of us is making decisions about patients, and about the policies and procedures that are guiding the work of each our organizations. We also learned that we need different experts around the table, including EMS and community agencies, especially for this particular person. (continued on page 2)

What It Means to be a Partner:

Currently 25 organizations have partnered with McMaster DFM/FHT. A cooperating partner sees the work of HCHL as valuable to their organization and to the people they aim to serve. Partners are committed to the work, and will aim to orient their staff, management and boards to be conscious of and responsive to this work. Partners are committed and willing to study data and information related to people who make frequent hospital visits; to help to develop person-centred solutions; to reflect on their organization's impact on this issue; to work toward changes in their organization that could enhance your impact; and, to work with other HCHL partners to advocate for changes at higher levels where appropriate.

Quote

Paul Johnson - Director, Neighbourhood Development Strategies - City of Hamilton, member of the HCHL Advisory Board, and active participant in developing this business plan.

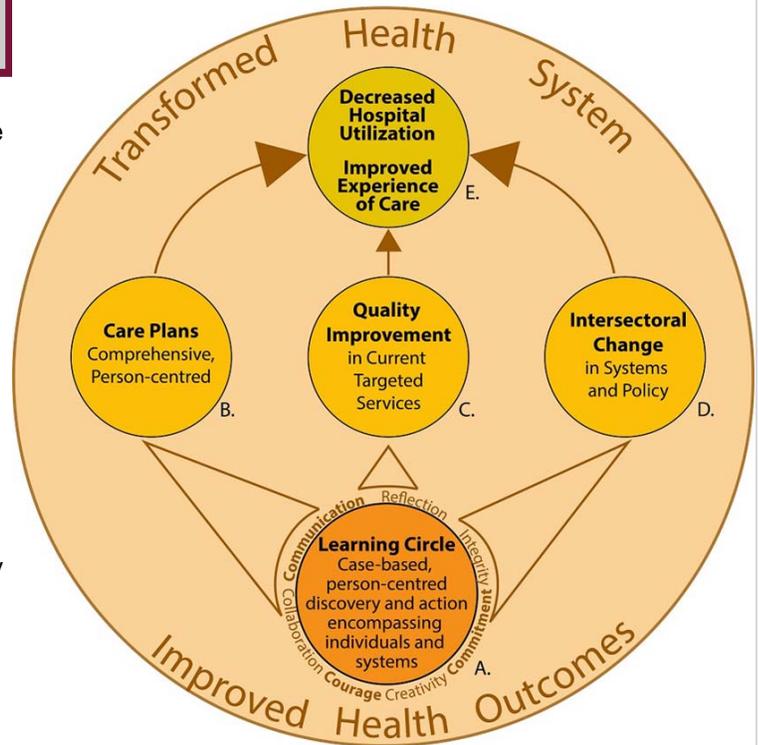
The early stages of the launch of the Hamilton Central Health Link (HCHL) initiative is another example of how the community is working together to build a strong, healthy city. It has been clear from the beginning that our partners in the health sector are committed to this initiative. It is also clear that all of those involved understand that improving health outcomes for residents of Hamilton requires the skills and resources of a broad array of partners including the Municipality and community-based service providers. This holistic approach is very much in keeping with the City's Neighbourhood Development Strategy, which is focused on improving the health, economic and social outcomes of residents in many of the neighbourhoods included in the HCHL initiative. We look forward to working with the HCHL "team" and discussing new ways to better address the health needs of those in our community.

Transformation Plan

Create Comprehensive Person-Centred Care Plans (Circle B): Our region has within it many types of service coordinating roles: case managers, system navigators, care navigators and others. These are housed in a variety of organizations: hospitals, family health teams, community health centres, social service agencies, assisted living locations, and many more. One person may receive service from several of these, and it is often not clear if one coordinator plays the primary role. There are many different philosophies, models and approaches being used, and a variety of different goals being achieved.

Quality Improvement for Current Targeted Services (Circle C): There are many programs and services already being implemented in this community that explicitly or implicitly include the aim of reducing hospital utilization. We have developed an initial inventory of these, and will maintain this inventory to be able to constantly review their function, quality, impact and value to the community overall.

Intersectoral change in Systems and Policy (Circle D): We predict that our Learning Circle activities will help to illuminate where system and policy factors are helping and where they are hindering our attainment of the aim. Where these become clear, the Partners will determine how to advocate for change in these systems and policies at relevant levels of administration and governance.



Learning Circle Pilot Group

The following people are currently included in the Learning Circle Core Group:

- David Price, Dale Guenter, Tracey Carr, Anne Childs, Cathy Risdon, and Lisa Patterson from McMaster DFM/FHT
- Brenda Flaherty, Kelly O'Halloran and Clare O'Connor from HHS; Jane Loncke and Helen Harris from SJHH; Barb Busing, Elizabeth Bonney and Janet Nobel from CCAC; Jim Williams and Ruth Morris from HFTH.

HCHL Mission, Aim and Philosophy

Our Mission: *To Transform the health system to maximize the health and health care experience of people in our region.*

Our Primary Aim: *To decrease hospital admission and emergency department (ED) visits among the top 5% cohort in this region.*

Our Philosophy: *That the quality of provider-person and provider-provider relationships is what determines the quality of the health care experience and its impact. Relationships will be improved by embracing all forms of success and failure as essential elements of the learning process, through conversations that invite thoughtful risk and avoid simplistic explanation.*

In the Media

Dr. Dale Guenter, Donna Cripps and Bill Krizmanich (McMaster University) were interviewed on January 29th, 2013 by Steve Buist from The Spec. The article appeared in The Spec on February 16, 2013, the website link is <http://www.thespec.com/news/local/article/888247--life-line-examining-chronic-hospital-users>.

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Newsletter Desk

monthly. We believe this type of communication will help keep everyone up to date with all the of HCHL news. Please feel free to contact us with any comments and/or suggestions for the next newsletter.

The HCHL Newsletter will be circulated bi-



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