MY HEALTH TEAM

My Health Team Priority 3
Service Planning Guide

My Health Team: _____

Date of Submission: _____

Manitoba

Version 4.0 (October 2017)

BACKGROUND

The purpose of this document is to act as a workbook to guide MyHTs through the process of service planning, such as the process for identifying net new services, as well as describing plans to re-design, improve or augment existing services from the first two years. Specifically, as their 3rd Priority, MyHTs will develop and implement plans that work towards promoting 2 main deliverables including Access for all people within a MyHT area, and Service Coordination for patients with complex needs and underserved populations. ***This template is meant to support MyHTs in achieving these deliverables in a way that best suits their needs and context, by not only listing work to be completed but also offering topics for consideration and options for interventions. That being said, Manitoba Health, Seniors and Active Living (MHSAL) understands that all of this work will take several years to implement and offers MHSAL Liaisons' assistance to guide you through the template and the MyHT planning process.***

The Steps in the MyHT Service Planning include:

Step 1: Review Target State

Step 2: Current State

Step 3: Access

3a Timely Access Worksheet
3b Access Plan

Step 4: Service Coordination & Outreach

4a Service Coordination Worksheet
4b Outreach Worksheet
4c Service Plan

Step 5: Engagement/Expansion Plan

Step 6: Budget

The Service Plan has been developed in a template format. Please note, **worksheets in the template are necessary brainstorming steps required in this service planning process and will help you in completing your Access Plan (3b) and Service Plan (4c)**; however, they are not necessary in the formal submission and approval of the service plan. All other sections must be completed **in blue** within the template provided. Additional space may be required to complete some sections.

NOTE: the following are example sources of information that may be useful in completing the questions within this template:

- *Family Doctor Finder data*
- *Canadian Community Health Survey data*
- *Community Health Assessment data*
- *Provincial Health System Indicator Portal data*
- *Manitoba Youth Health Survey 2012-13*
- *The 2013 RHA Indicators Atlas*
- *Electronic Medical Records (EMR) data*
- *Analytic Reports (Primary Care Data Extracts)*
- *Primary Care Capacity Planning (Hot Spots)*
- *Canadian Triage & Acuity Scale data*
- *Analysis from pts and providers*
- *Primary Care Patient Survey*
- *MyHT Evaluation*
- *Research: SPOR PICHI, MCHP, CIHI*
- *Perspectives Provincial Mental Health Network*
- *Family Feedback*
- *Community Feedback*
- ***Patient Feedback***

STEP 1: REVIEW TARGET STATE

The ultimate target for a MyHT is to support accessible, comprehensive, and continuous services for all the patients in its defined population. In an effort to work towards this goal, this service plan includes the following deliverables:

Target State: ACCESS, COMPREHENSIVENESS & CONTINUITY				
Deliverables:	**ACCESS**		**SERVICE COORDINATION**	**OUTREACH**
Population:	***All within MyHT Area***		***Pts with Complex Needs <u>AND/OR</u> Underserved Populations***	
PAST PLAN *Priority 1 & 2*	Attach 2000 patients.	Measure timely access indicators.	Deliver services targeting patients with complex needs.	
CURRENT PLAN *Priority 3*	**a.** Maintain and continue to **attach** patients without a provider.	**b.** Develop and <u>implement</u> a phased plan for how the MyHT will work towards **access within 24 to 48** hours to primary care (includes extended hours) and self-management resources.	**c.** Develop and <u>implement</u> a plan to leverage community resources by better **integrating and coordinating services with an organization or RHA/community program** for seamless hand-offs.	**d.** Develop a <u>plan</u> to deliver **outreach** services to underserved population(s).
ONGOING PLAN Priority 4, 5…	*Attachment/Enrolment will remain a priority as long as patients require a provider.*	*Continue to implement and maintain timely access plan.*	*Update and expand plan to continue leveraging additional community resources.*	*Update and implement plan to deliver outreach efforts.*

TBD
…

Patients with Complex Needs *are defined as the highest users of health services in the MyHT area, having multiple chronic medical conditions and/or other factors, such as advanced age, mental illness, addictions, physical and/or mental challenges, and/or treatment with multiple medications.*

Underserved Populations *(also referred to as vulnerable, marginalized, and hard-to-reach populations) are defined as those who experience obstacles with service availability, service access, or the quality of treatment obtained, beyond what the average Manitoban would face, such as cultural, socio-economic, age and geographic location. For MyHT purposes, underserved refers to an increased likelihood that individuals will, because of their membership in a certain population: experience difficulties in obtaining needed care; receive less, or a lower standard of care; experience differences in treatment by health personnel; receive treatment that does not adequately recognize their needs; or, be less satisfied with health care services (Bowen, 2000).*

STEP 2: CURRENT STATE

a. UPDATE P2 CURRENT STATE *(if applicable)*: Summarize only significant changes to the current state since your last service plan.

b. IDENTIFY MyHT'S UNDERSERVED POPULATIONS FOR P3 PLANNING: Below is a list of examples of population groups that, according to research, are at greater risk of experiencing unmet health needs due to barriers preventing access to care.[1, 2] Based on your data and knowledge of your MyHT's current readiness to address access barriers, please identify the top three underserved populations that could be best served by the MyHT at this time.

Persons with Disabilities	*Inner-city, rural, or remote*	*Language minority*	*Addictions*
Sexually Transmitted and Blood Borne Infections	*Immigrants or Refugees*	*Teen Parents*	*Homeless*
First Nations, Métis and Inuit populations	*Low Socioeconomic Status*	*Mental Illness*	*Frail elderly*

POPULATION	**DESCRIBE THE POPULATION & ISSUE**	**RATIONALE** (Prevalence/ Incidence, Existing Community Resources) – see page 2 for list of potential information sources).
1.		
2.		
3.		

c. ACCESS BARRIERS: If known, record barrier(s) that are believed to be key root causes affecting the availability, acceptability, or accessibility of care from a patient's perspective.[3,4] This will be used to inform work related to underserved populations in this template.

ACCESS BARRIERS *Ideally Informed by Patient Sample or Patient Advocates*	Service not available in area	Service not available when required	Waiting time too long	Belief that service would be inadequate	Cost (meds, devices, treatments)	Pt didn't get around to accessing care (e.g., too busy)	Unsure where to go	Dislike/fear doctors	Language barriers	Family responsibilities (e.g. child care)	Pt chose not to seek care	Time off work for appointments	Pt did not have a regular primary care provider	Cultural beliefs/ norms	Immobility (physical or mental disabilities)	Cognitive well-being	Lack transportation	Pt fear of stigma or being discriminated against	Other:_____
1.																			
2.																			
3.																			

[1] Hay, D. I., Varga-Toth, J., & Hines, E. (2006). Frontline health care in Canada: innovations in delivering services to vulnerable populations (Research Report F|63, Family Networks). *Canadian Policy Research Networks*, p. 1 – 96.
[2] Health Canada. (2001). "Certain circumstances": Issues in equity and responsiveness in access to health care in Canada (Catalogue No. H39-618/2002E), p. 1 – 256.
[3] Sibley, L. M., & Glazier, R. H. (2009). Reasons for self-reported unmet healthcare needs in Canada: A population-based provincial comparison. *Healthcare Policy*, *5*(1), 87 – 101.
[4] Canadian Medical Association. (n.d.). CMA position statement: Ensuring equitable access to care: Strategies for governments, health system planners, and the medical profession. Retrieved from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/PD14-04-e.pdf

STEP 3a: TIMELY ACCESS WORKSHEET

Step 3a includes tools that we encourage the MyHT to work through, in order to identify interventions that will help them move towards achieving access to primary care within 24 to 48 hours (including extended hours and self-management resources) in their timely access plan. This tool, or other tools you may have access use, will be used to inform Section 3b of your Service Plan. MyHT Liaisons are available to facilitate this exercise upon request.

In the process of identifying and prioritizing interventions, please review and consider the following data sources:

a) MyHTs' access indicators collected in Priority 2 for each clinic in a MyHT
b) MyHTs' general knowledge of their own barriers to timely access
c) Intervention criteria as follows:

Effectiveness	*Which would have a significant impact in improving timeliness of access to one or multiple services?* *Which would support timely access for the most MyHT clinics?*
Efficiency	*Would there be overlap in any of the interventions selected or with existing efforts underway?*
Sustainability	*Which would be the most sustainable interventions or support long-term improvements?*
Affordability	*Which interventions require the least amount of resources or would be the most affordable?*
Feasibility	*Which interventions could be implemented with limited effort or obstacles (e.g., clinic environment, organizational structure, time commitment, existing data collection, technical difficulties)?*
Alignment	*Which improvements could promote access for patients with complex needs or underserved populations, self-management, continuity of care, patient-centeredness, service coordination, patient engagement etc. or other primary health care targets?*
Timing	*Which interventions should be implemented now, next year, or in the future? Why? (e.g., dependencies)*

INTERVENTION OPTIONS [5, 6, 7]: Using the information above, please rank ALL interventions from 1 to 3; 1 indicating the highest level of significance that the intervention could have to one or more of the MyHT partners. ***Note, you are not being asked to complete all interventions selected in one year; rather, MyHTs will prioritize interventions and implement them using a phased approach.***

[5] Manitoba Health, Seniors & Active Living. (n.d.). Advanced Access: Moving forward in MB. Retrieved from: http://www.gov.mb.ca/health/primarycare/providers/access/advancedaccess.html
[6] The College of Family Physicians of Canada. (2012). Timely access to appointments in family practice. Retrieved from: http://www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/2012_Final_Best_Advice_Enhancing_Timely_Access.pdf
[7] Health Quality Ontario. (2011). Advanced access and efficiency workshop for primary care. Retrieved from: http://www.hqontario.ca/Portals/0/documents/qi/primary-care/qi-aae-interactive-workbook-en.pdf

1:	Significant value to one or more MyHT partners

2:	Of some value to one or more MyHT partners

3:	Of minimal or no value to any MyHT partner

Rank 1-3	**SUPPLY** **Definition:** *The number of providers and how many clinical hours they are available to see booked patients (Number of appointment slots available).* **Goal:** *Balanced ratio between number of appointments available and appointments actually filled.*	*Rank 1-3*	**DEMAND** **Definition:** *The number of appointments booked in a day (regardless of the day of the actual appointment).* **Goal:** *Balanced ratio between number of appointments available and appointments actually filled.*
	Leverage existing community resources to increase the supply of related services, such as QuickCare Clinics, Mobile Clinics, Telehealth, Mental Health Program etc.		Use and educate patients on alternate methods of care delivery, so they may understand the team approach (e.g., nurse visits, self-care, TeleCare, QuickCare, group visits).
	Maximize provider and staff schedules to meet patients' needs (e.g., time away policies and processes; clinic schedules avoid gaps in availability across the MyHT).		Use checklists to ensure the provision of comprehensive care delivery at each visit, and to avoid a later visit. The use of age-specific guidelines can optimize planning for the patient's visit.
	Ensure providers are working to their full scope of practice.		Reduce internal demand by extending revisit rates.
	Identify team roles and the process for providing care and advice to patients using agreed-upon guidelines.		Promote continuity of provider, as patients who see a trusted provider generate fewer revisits.
	Hire temporary resources (e.g., team member, locum).		Reduce "No Show" appointments (e.g., reminders, timeliness).
	Temporarily increase the supply of visits by adding appointments to the beginning or end of the day.		Do as much as possible at every visit to reduce the need for future visits.
	Develop a role for team members to manage sub-populations of patients (e.g., CHF, hypertension).		Inform planning by tracking unplanned activities, such as provider add-on appointments, vacancies, no-shows, etc.
	Use Group visits and/or Shared Medical Appointments		Encourage patient engagement and self-management.
	Develop multi-skills staff by cross-training staff		Consider whether follow-up appointments are needed.
Rank 1-3	**PANEL SIZE** **Definition:** *the number of unique individual seen by a provider within a determined timeframe (e.g., 18 months)* **Goal:** *Equal distribution of workload across MyHT clinics.* **Note: Consideration must be given to social complexities when determining panel size.*		Only distinguishing between short and long appointments, not between urgent and routine ones.
			Anticipate unusual but expected events (e.g., chronically late patients, patients who bring family members).
			Standardize clinic appointment lengths using basic units of time blocks (e.g., 5 or 10 min) to create ability to expand or shorten appointments to meet demand.
	Determine where there is currently capacity to take on more patients.		Choose a quieter time to work down backlog.
	Adjust panel size to match provider EFT time in clinic to see patients- redistribute workload to other MyHT providers		Manage demand variation proactively (anticipate patient needs and seasonal fluctuations, e.g., flu shots).
	Work with regional Primary Care Connector to attach more patients where there is capacity.		Cycle time measurement tracks the actual length of several consecutive appointments, in order to inform a schedule template that matches the reality of the provider's pace.
	Leverage Family Doctor Finder resources.		

Rank 1-3	**DELAYS** **Definition:** *Patients waiting when the demand for health care services exceeds the supply.* **Goal:** *Timely access to services.*	*Rank 1-3*	**OFFICE FLOW** **Definition:** *Patients waiting due to inefficiencies related to office supplies and processes.* **Goal:** *Decreased wait times and added value to the process time by improving general clinic flow (by optimizing the use of rooms, staff time, and equipment).*
	Create a plan to reduce the backlog (i.e. add additional appts, extra clinics, etc.)		Use rooming criteria to get patients ready (e.g., shoes and socks off for patients with diabetes).
	Set begin and end dates for backlog reduction.		Note the reason for visit to ensure that team is prepared.
	Doing today's work today- after eliminating backlog.		Eliminate identified wastes or inefficiencies.
	Review bookable hours (Too many? Too little? Do they need to be expanded?).		Communicate to patients the amount of time available for the appointment – engage patients to help stay on time.
	Use open access scheduling to provide appointments the same day a patient is looking for one.		Choose lab tests and referrals wisely; limiting ordering to evidence-based care.
	Develop and implement plans for booking providers who are away from the office (i.e. vacation, etc.) and for their return to the office.		Use technology to synchronize and automate information sharing between providers and with patients (EMRs, e-mail, patient portals).
	Reduce "No Show" appointments (e.g., reminders, timely).		Create a process to manage and distribute all communication.
	Assign dedicated phone line to take messages from patients (incl. prescription information).		Using correct forms, completing forms appropriately, and attaching appropriate documentation.
	Daily huddles to review office flow and proactively match demand and supply. (e.g., sick calls, special patient needs, staff flexibility, contingency plans).		Map office flow and identify bottlenecks to improve efficiency or reduce the number of steps in the process. (e.g., Handling paper more than once).
	Use standard template for message taking and action.		Standardize stock/inventory for clinic and exam rooms.
	Eliminate paper messages (where possible).		Start the first appointment on time (a.m. & p.m.)
	Assign most appropriate care team member to do non-appointment work.		Identify work (e.g., administrative tasks) that providers do outside the appointment that could be done by another staff member.
Rank 1-3	**OTHER**		Maximizing EMR use (e.g., form completion; reminders).
	Documented and agreed upon care coordination protocols, agreements, processes, pathways, workflow maps.		Address equipment gaps to reduce steps (e.g., printer or blood pressure monitors in all exam rooms).
	Competing clinical and administrative priorities (e.g., ER and Personal Care Homes duties, administrative work…)		Guiding interview to ensure appointment time is utilized as efficiently as possible.
	Long-term planning (e.g., Regional Health Plan, Primary Care Capacity Planning, Workforce Planning…)		Develop non–verbal cues to communicate without halting work (e.g., computer icons to signal readiness for next patient).
	Minimize impact of barriers outside of the MyHT's control		**Other(s):**

B) NEXT STEP: Please include in Section 3 B of this Service Plan, which access interventions could be **reasonably** taken on in this priority by each of the MyHT Partners. Note: What is considered reasonable is dependent on the MyHT's current status and context. Please consider the steps necessary to prepare and facilitate implementation of other interventions in future years.

STEP 3b: ACCESS PLAN

ACCESS INTERVENTIONS. Based on the Timely Access Worksheet (from Step 3a), please summarize those interventions MyHT partners plan to take on this year (both in terms of efforts currently underway and potential new initiatives). This includes a description of the plan for implementation (e.g., activities, timelines) and measurements of success (i.e., how the outcome of improved access will be measured).

*Please note, by including an intervention you are identifying that you are working towards its completion, not that it must be successfully completed by the end of the year. What is considered reasonable is dependent on the MyHT's current status and context. Please consider the steps necessary to prepare and facilitate implementation of other interventions in future years.

MyHT CLINIC (may include RHA program partners)	**DESCRIBE ACCESS INTERVENTIONS**	**PLAN FOR IMPLEMENTATION**	**MEASURE OF IMPROVED ACCESS**
1.	a) b) c)	a) b) c)	a) b) c)
2.	a) b) c)	a) b) c)	a) b) c)
3.	a) b) c)	a) b) c)	a) b) c)
4.	a) b) c)	a) b) c)	a) b) c)

Additional Resources:
The accompanying document, titled *Timely Access to Appointments in Family Practice* published by the College of Family Physicians of Canada (CFPC) will similarly provide information on strategies that support timely access to appointments in primary care settings. Strategies for timely access to appointments are a core element that has been recommended for newer models of practice, in keeping with the CFPC's *Patient's Medical Home* at www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf.

4a: SERVICE COORDINATION WORKSHEET

Step 4a, in addition to other tools you may have access to, will act as a tool to guide the integration with an organization or RHA/community program. By leveraging existing resources, this will allow for the introduction of new services or the expansion of existing services in a way that is more seamless, sustainable, and supports the idea of providing the "right care, by the right provider, at the right time." MyHT Liaisons will be available to facilitate any step of this exercise.

a) IDENTIFY POPULATION[8]: Based on your current knowledge of patients with complex needs (identified in Priority 2) and underserved populations (identified in Step 1), list 3 population groups for which the MyHT would have the greatest impact and would best align with the MyHT's existing work. Please also consider some existing organizations or programs providing services to those populations that are not well integrated throughout the MyHT (but that could potentially be leveraged to do so).

POPULATION	POTENTIAL ORGANIZATION OR PROGRAM PARTNERS
E.g., Persons with Diabetes	*Diabetes & Heart Health Program, TeleCARE MB, Population & Public Health Nutrition Program*
1.	
2.	
3.	

b) ORGANIZATION/PROGRAM SELECTION: Based on your knowledge of existing resources, identify and describe the organization(s) or program(s) best positioned to be integrated with the MyHT. In the event that a MyHT has difficulty prioritizing what organization or program to integrate, please see Appendix A for instructions on how to complete an Affinity Diagram. Please note, the organization or program can be the same or different from those identified in previous years. For example, the MyHT may:

1. Integrate with an organization or program targeting patients with complex needs that the MyHT already works with.
2. Integrate with a new organization or program targeting the same group of patients with complex needs but using a different program not currently spread throughout the MyHT.
3. Integrate with a new organization or program targeting a completely new population group (not currently targeted within the MyHT's existing services), whether for patients with complex needs or underserved population groups.

POPULATION	PARTNERS	DESCRIBE RATIONALE
E.g., Persons with Diabetes	*Diabetes & Heart Health Program*	*Multidisciplinary treatment and education to those who have or are at-risk of diabetes or heart disease. Program includes group and individual sessions to address lifestyle changes and teach self-management skills. Also offers intensive insulin management support including pump therapy. […]*

[8] Note: Any group identified as significantly underserved, but who cannot be addressed through MyHT work, should be flagged for MHSAL and RHA and addressed in some other capacity.

c) IMPLEMENTATION SERVICE COORDINATION ACTIVITIES: The table below includes a sample list of activities that could assist the integration of the selected organization(s) or program(s) with the MyHT. Please identify at least 2 activities that best suit the population and program(s) selected above, and describe how these measures might support successfully integrating the selected organization or program with the MyHT, in accordance with MHSAL's standards and best practices.[9] **MHSAL understands it may require over a year to implement these standards and best practices and acknowledges that some of this work may be dependent on provincial progress as well (e.g., ICT and information-sharing).** Please note: this work is meant to support the communication and hand-offs between the MyHT and the selected program/organization; that being said, the long-term goal is for the MyHT to continue to expand and achieve this level of integration with all of its prospective partners. **Additional descriptions and resources available upon request.* [10]

E.g., ACTIVITIES	
i. *The purchase, installation, and maximized use of supportive **space**, **software, technologies**, **equipment** or **products**.* ii. *The delivery of **consultations**, **workshops**, **team-building sessions** or other types of **education** and **training**.* iii. *The implementation of documented and agreed upon: **policies**, **procedures**, **agreements**, **protocols**, **guidelines**, **processes**, or **pathways**.*	
STANDARDS How people should experience coordinated services.	**BEST PRACTICES** Activities providers should engage in to achieve standards.
1. TIMELY ACCESS	**1. INTER-PROFESSIONAL ACCOUNTABILITY**
• *E.g., How will the public be made aware of these new services?* • *E.g., How will integration improve access to timely/quality services?*	• *E.g., How will this organization/program and the MyHT ensure provider accountability for all patients?*
2. COMPREHENSIVE PERSON-CENTERED SERVICES	**2. PERSON-CENTEREDNESS**
• *E.g., How will integration ensure patients feel that their unique needs are heard and are a priority?*	• *E.g., How will integration promote health equity and prioritize the needs and goals of individuals, their families, and communities (over the system's)?*
3. ENGAGEMENT & SELF-MANAGEMENT	**3. COLLABORATION, INTEGRATION & PATNERSHIPS**
• *E.g., How will integration ensure user-friendly service delivery?* • *E.g., How will integration empower patients to be engaged participants in their care and self-manage their health or condition(s) (if willing/able)?*	• *E.g., How will this organization/program and the MyHT facilitate communication and collaboration between providers to ensure clarity re: roles and expectations?* • *E.g., What is the shared vision of what integration will look like?*
4. CONTINUOUS SERVICES	**4. STANDARDIZED DOCUMENTATION & TRASMISSION OF INFO**
• *E.g., How will the MyHT encourage:* ○ *Timely and reliable information transfer and sharing with this organization/program?* ○ *A consistent relationship between a patient and his/her most responsible provider when referred out to this organization/program?* ○ *Seamless access to prevent gaps in care when referred out to this organization/program?*	• *E.g., How will this organization/program standardize and automate the documentation and transfer of information to support timely and complete information collection, sharing, and updating; between providers or with patients?*
	5. CONTINOUS EFFEICIENCY IMPROVEMENT PROCESSES
	• *E.g., What modes of continuous quality improvement will be used to monitor and support the integration of this organization/program?*

NEXT STEP: **The integration of an organization/program with the MyHT is an "activity" the MyHT is responsible for in Priority 3. See Step 4c "Service Plan" for guidance on the implementation and evaluation of this activity.**

[9] These standards and best practices are based on the Service Coordination Framework developed in 2015.
[10] Kreindler, S. A. (2012). Increasing integration: What does the evidence say? Winnipeg, Manitoba: Winnipeg Regional Health Authority.

STEP 4b: OUTREACH WORKSHEET

Step 4b assists with conceptualizing outreach services that align with the population needs and the resources available to provide services to underserved populations who face barriers preventing them from seeking out primary care. Note, while an implementation plan for outreach services must be developed in Priority 3, the **actual implementation of that plan is not required until Priority 4.**

a) DETERMINE POPULATION[11]: Based on the MyHT's knowledge of the access barriers and existing community resources, identify and describe the population group that would likely experience the greatest impact re: access to primary care and best align with the MyHT's existing work. It is recommended that the population selected be the same as the one targeted in Step 4a, though it is not a necessity.

POPULATION	

b) OUTREACH ACTIVITIES[12]: Please select (X) and describe the outreach option(s) that would have the greatest impact and would best align with the MyHT's existing work. Your selection must include a minimum of one outreach option from Tier 1. In the event that a MyHT has difficulty selecting the most appropriate outreach options, see Appendix A for instructions on how to complete an Affinity Diagram. MyHT Liaisons will be available to facilitate this exercise upon request.

☒	OUTREACH ACTIVITIES: TIER 1	DESCRIBE
	a) Relocate providers to underserved communities for a portion of their time.	
	b) Add outreach services to existing providers' repertoire (e.g., home, local, or program visits).	
	c) Work with local organizations, community health centers, public health departments, etc. to develop, support, and/or leverage the delivery of new/existing outreach efforts.	
☒	**OUTREACH ACTIVITIES: TIER 2**	**DESCRIBE**
	d) Develop a process (e.g., pathways) to connect patients to community-based organizations and RHA programs with needed primary care and/or other health, education, or social services.	
	e) Use communication technologies (e.g., Telehealth) to delivery health services or information.	
	f) Assessments to determine unmet service needs (e.g., Poverty Tool; Screening, Brief Intervention Referral)	
	g) Public education (e.g., print/audiovisual resources; community-based education, awareness day)	
	h) Provider education (e.g., cultural competence; spiritual health competencies).	
	i) Targeted preventative and early detection programs.	
	j) Community development & relationship building.	
	k) Other:	

c) IMPLEMENTATION & NEXT STEPS: The implementation of outreach services is an "activity" the MyHT is responsible to introduce in **Priority 4** (though it is understood that full implementation may require over a year). To successfully prepare for Priority 4, MyHTs are being asked to develop an implementation plan, which considers how they will introduce the services selected. See Step 4c "Service Plan" for guidance on the implementation and evaluation of this activity. Note: MyHTs should continue to consider what other populations in their MyHT area may require outreach services in the future (beyond Priority 4) and what resources could be leveraged to do so.

[11] Note: Any group identified as significantly underserved, but who cannot be addressed through MyHT work, should be flagged for MHSAL and RHA and addressed in some other capacity.

[12] Health Canada. (2001). "Certain circumstances": Issues in equity and responsiveness in access to health care in Canada (Catalogue No. H39-618/2002E), p. 1 – 256.

STEP 4c: SERVICE PLAN

Section 4c will guide MyHTs in updating the implementation plan for each of their existing services, as well as each of the new service additions to the P3 Service Plan, which broadly will involve defining the goals, operational requirements and measurements for each activity. This work is meant to reflect a PDSA and quality improvement approach, as a way of supporting gradual improvements for significant and sustainable system change, rather than pilot initiatives.

i. ***UPDATE P2 IMPLEMENTATION PLAN FOR EXISTING SERVICES***: Please fill in the following table for each existing service that was implemented in Priority 2:

Service: *(Name)*

Did this service do what it was intended to do? Explain. (e.g., what worked, what didn't, and what would need to change?)	
Describe the results of this service based on the Priority 2 expected outcomes and deliverables.	
Describe any considerations or plans for changes to this service, including plans to terminate any aspects or processes. (e.g., expand it, tweak and re-test, stop).	
Could this existing service also address health outcomes for other patients with complex needs or underserved groups? How?	

ii. ***SUMMARIZE P3 IMPLEMENTATION PLAN FOR NEW SERVICES:*** Step 4a and 4b represent worksheets that the MyHTs can use to work through to inform Step 4cii below. To further support the implementation and evaluation of each of these activities, please complete all applicable sections of the template below for each NEW service, capturing the plan for both of the following activities:

MyHT Deliverable	Section of Service Plan	Activity
Service Coordination	Step 4a	Implementation of integrating with an organization or RHA/ community program
Outreach	Step 4b	Implementation of outreach services *Please note, while an implementation plan for outreach services must be developed in Priority 3, the actual implementation of that plan is not required until Priority 4.

SERVICE TO BE IMPLEMENTED: *(Name)*

<table>
<tr><td rowspan="2">Target Population</td><td>What is the target population for this service?</td></tr>
<tr><td></td></tr>
<tr><td rowspan="2">Issue Statement
• Population Need</td><td>Describe the purpose/main functions of the service or the specific issue this service planning to address. Is there information or data that can be included to validate?</td></tr>
<tr><td></td></tr>
<tr><td rowspan="2">Target State
• Attachment
• Timely Access
• Service Coordination
• Outreach</td><td>What is the target state for this service and how will it assist in meeting MyHT deliverables?</td></tr>
<tr><td></td></tr>
<tr><td rowspan="2">Describe the Service
• Integrate organization/program
• Outreach service</td><td>Describe what the service will entail, including its key components of how it will work overall.</td></tr>
<tr><td></td></tr>
<tr><td rowspan="2">Rationale
• Current State (Step 2)
• What would best align with existing MyHT work
• Affinity Diagram (Appendix A)</td><td>Highlight the main points that rationalize the prioritization of this service over another.</td></tr>
<tr><td></td></tr>
<tr><td rowspan="2">Target Location
• E.g., Name of community area
• Type (clinic/ centre/ shelter)
• Name of specific location</td><td>Provide details re: ALL the location(s) of where service will be implemented.</td></tr>
<tr><td></td></tr>
<tr><td rowspan="2">Responsibility</td><td>Who is responsible for the start-up AND ongoing implementation/monitoring of this service? What are they responsible for? Are others involved or impacted?</td></tr>
<tr><td></td></tr>
<tr><td rowspan="3">Implementation Requirements
• E.g. Staffing, hours
• The purchase, installation, and maximized use of supportive space, software, technologies, equipment or products. (EMR pathways; Health Links; eReferrals; integrated digital health system solutions; Centralized information, intake, and referral)
• The delivery of consultations, workshops, team-building sessions or other types of education and training. (Defining a MyHT; role clarity/ scope of practice; standard and</td><td>PART A: Describe steps required to effectively implement the service in the current system. This includes recording what the MyHT must acquire, develop, or modify for the start-up AND ongoing implementation of this service considering other team members and services. Summarize how the MyHT plans to achieve this (including any important timelines).</td></tr>
<tr><td></td></tr>
<tr><td>PART B: Of the resources necessary to the implementation of this service, are there some that are already in place within the region? Yes ❑ No ❑

If yes, please describe the components.
<table><tr><td>RHA</td><td></td></tr><tr><td>FFS Physician(s)</td><td></td></tr><tr><td>Community Organization</td><td></td></tr></table>
Are there existing resources that will be allocated to the implementation of this service? Yes ❑ No ❑
If yes, please describe this resource.</td></tr>
</table>

best practices; developing communities of practice)

- The implementation of documented and mutually agreed upon: **policies**, **procedures**, **agreements**, **protocols**, **guidelines**, **processes**, or **pathways**. (*Standards; best practices; decision supports; communication processes; care plan/ discharge/ transfer agreements re: role clarity, documentation, monitoring, evaluation etc).*

RHA	
FFS Physician(s)	
Community Organization	

Are new resources required to operate the service/requirement? Yes ❑ No ❑
If yes, please describe the resource.

MyHT	

Expected Output/ Outcome

Describe how you plan to measure the success of the service? What are the measurable targets and results expected?

Expected Output/ Outcome	***Indicator***	***Definition***	***Frequency***	***Target***	***Data Source***	***Owner***	***Measured Now?***
E.g., Attachment	*Net new pt attached*	*MHSAL Algorithm*	*Quarterly*	*2000*	*EMR Extract*	*Clinics*	*Yes*

Dependencies

Will other services/resources affect the implementation of this service? Yes ❑ No ❑

If yes, describe what services/resources (including elements, events, issues, etc.) that are outside the control of the MyHT that may impact the integration or implementation of this service. If negative, please include how this will be mitigated.

Planned Communications

Consider any new audiences, issues or key messages relevant to your new services that will need to be included.

What messages need to be developed and delivered about this service? To whom? How will the MyHT communicate these messages? Is there a timeframe for the messaging?

Budget Requirement

Review the funding principles and ensure each member considers existing resources that can be allocated to support the service before the need for net new resources are identified.

$ _____

Service Start Date

Include the date in which this service is expected to be implemented.

Other

List any other considerations for this service.

STEP 5: ENGAGEMENT/EXPANSION PLAN

Step 5 is intended to focus on the Expansion of the MyHT Network. MyHT Members must plan to incrementally expand the geographical reach of the MyHT through engagement of other communities, fee-for-service practices, and community organizations. Although the MyHT may begin with limited members (e.g. only one or two fee-for-service practices), the planning team needs to prepare to broaden and grow the MyHT team over time. Each year the MyHT is required to provide an updated expansion plan to demonstrate how the MyHT plans on stimulating engagement of and expansion to new communities and MyHT partners (both formally and informally).

Any expansion plan should be the result of a thorough brainstorming session and must include the following key points:

- A list of community areas that a MyHT plans to expand to
- The population and a description of other characteristics of the communities.
- A list all potential stakeholders that could be engaged formally and informally with the MyHT from the community area.
- A description of the current level of engagement for each potential stakeholder listed.
- A description of the desired level of engagement for each potential partner listed.
- Strategies the MyHT plans to use to engage and attain the desired level of involvement for those prospective partners.
- A timeline for implementing the listed strategies.
- A designated lead accountable for the implementation of each strategy.

Please **summarize key points of your expansion plan** (listed above).

Example:

Community/ Community Area	Population & Community Characteristics	Potential Stakeholders/ Partners to Engage	Current Level of Engagement	Desired Level of Engagement *Include whether this involves an informal or formal partnership*	Strategies/ Next Steps	Timelines *When is the MyHT expected to reach this community?*	Lead

* The *MyHT Engagement Guide* (attached as an Appendix B), in addition to other tools you may have access to, will act as a workbook and tool to providing further detail to guide this process but is intended to be used for your own purposes and is not required to be attached to this submission.

STEP 6: BUDGET

1. **Budgeting** – In this step you will develop a budget for the MyHT. For a summary template of the budget, please see Appendix C.

   While it is recognized that some MyHT funding may be required to support administration, clinic support, and physician leadership/engagement (up to ~20% of budget), it is expected that the majority of MyHT funding (~80% of budget) will be allocated to augmenting direct service delivery for Manitobans. MyHTs may incur more one-time, start-up, and administrative costs during their inception. Therefore, the 20/80 guideline may not be proportional in the first few years of operations. However, there is an expectation that by Priority 4, the proportion follows the 20/80 guideline.

   Please have the budget reviewed by MyHT members' financial officers.

FUNDING

MyHTs are eligible for up to $675,000 (i.e., a $75,000 increment) in Priority 3, provided that the MyHT:

- Has submitted an acceptable yearly Progress Report demonstrating achievement on key milestones and targets.
- Has an approved Priority 3 Service Plan.
- Is generally up-to-date and in good standing respecting deliverables.

Year 1	Year 2	**Priority 3**	*Year 4**
$525,000	$600,000	**$675,000**	*$750,000*

* Up to $75,000 in incremental funding in Priorities 4 and 5 may be available.

Items Ineligible for MyHT Funding

Capital Costs	New builds, renovations.
Remuneration	*Direct payment to physician or specialist.*
Physician Education	*Physician leadership, engagement, consultations, or training for physicians that is not fundamental to the MyHT; for example, lunch and learns that could be done on a voluntary basis.*

Items Eligible for MyHT Funding

Direct Service	*FTEs: Document the FTE and classification (e.g. Nurse 2) and other assumptions used to derive the cost. The MyHT budget may not exceed second to top of scale plus 18% benefits for any position. If a successful candidate is entitled to salary above that level, the costs must be incurred by the RHA*.
Clinic Support	*On-site training, physical office space, office supplies, EMR licensing, ICT support.*
MyHT Administration and Support:	*Project management/ facilitation/ coordination, admin support costs, set-up, supplies, travel, meeting support, communications, etc.*
Physician leadership and engagement:	*Physician leadership (by 1-2 physicians) per MyHT within and between MyHTs; general compensation for other physician involvement (i.e. attendance at special meetings, consultation, training).*

SPONSORSHIP

Provide the names and signatures of at least one representative from each organization (Regional Health Authority, FFS primary care practice, and community organization) that has reviewed and accepted each section of the Priority 3 Service Plan.

FFS Primary Care Practice

Print Name:_____Position:_____

Signature:_____Date:_____

Community Organization

Print Name:_____Position:_____

Signature:_____Date:_____

Regional Health Authority

Print Name:_____Position:_____

Signature:_____Date:_____

NEXT STEPS

1. Review the completed MyHT Service Plan document with all MyHT members, MyHT members' financial officers, and your MHSAL Liaison prior to submission.

2. Please submit your completed MyHT Priority 3 Service Plan to:
   Barbara Wasilewski, Executive Director
   Primary Health Care
   Manitoba Health, Seniors and Active Living
   1st floor, 300 Carlton Street
   Winnipeg, MB R3B 3M9
   Email: Barbara.Wasilewski@gov.mb.ca
   Fax: 204-943-5305

3. MyHT members are invited to ask questions and seek clarification. Feel free to contact Laura Morrison, A/Director and MyHT Manager, at 204-788-6434 or at Laura.Morrison@gov.mb.ca.

APPENDIX A: AFFINITY DIAGRAM INSTRUCTIONS

Affinity Diagram: a tool that gathers ideas, options and/or issues and organizes them into groupings based on their relationships. It is used to group ideas generated by brainstorming. The idea is to meld the perspectives, opinions, and insights of a group of people who are knowledgeable about the issues. Unique features:

- Affinitize silently when organizing - this encourages unconventional thinking
- Go for gut reactions – speed rather than deliberation to keep the process moving
- Handle disagreements simply – make a duplicate of the idea and place one copy in each group.

STEP 1: Identify/Develop the Problem or Issue in a Statement or Question

STEP 2: Generate and display ideas (~15 minutes)

- Write the problem statement at the topic of the poster paper
- No discussion or comments occur during brainstorming
- Write down all ideas separately on post-its
- Post each idea on the poster paper

STEP 3: Sort ideas into groups (~15 minutes)

- Physically sort the post-its into groupings. This step should be done with little dialogue between team members; seek clarification only if an idea is unclear.
    - Place one or two similar or related ideas together in one column
    - Look for ideas that are related to those ideas and add to that column
    - Look for other ideas that are related and establish new column
    - Repeat until all the ideas are grouped (don't force loners into groups, let them stand alone)

STEP 4: Create header cards for the groups (~25 minutes)

- A header is an idea that captures the essential link among a group of ideas. It must consist of a phrase or sentence that clearly conveys the meaning of the group.
- Discuss and agree as a team on the wording of the headers.
- Write the header on a single different coloured post-it
- If you discover a relationship between 2+ groups, arrange them in columns under a superheader (same rules as creating headers)
- Place header and superheader post-its above groups of ideas

STEP 5: Document the finished Affinity Diagram (~5 minutes)

- Review and clarify the idea and groupings
- Document the finished Affinity Diagram (take a picture)
- NOTE: Use tape to reinforce the post-its before you roll the poster paper.

STEP 6: Review Affinity Diagram results together in large group (~30 minutes)

- Designate someone to present the results of your completed Affinity Diagram. MyHTs will rotate until all themes are presented
- Each MyHT will present one theme (header) from their Affinity Diagram.

SERVICE SELECTION: PRIORITIZING EXAMPLES

Example 1

Paired Weighting
Paired weighting is a method of ranking actions or options in priority order, by comparing each option to every other option and determining, for each comparison, which option is the higher priority of the two.

Instructions:

1. Finalize and number the options that you want to rank in priority order.
2. Option one is weighed against option two and the team decides which is the higher priority. The option that is the higher priority gets a point for the "win".
3. Then, compare option one to option three, four etc. Continue until every option has been compared to every other option once.
4. Notes should be recorded on the reasons why each option was picked as the higher priority in all the "head-to-head" comparisons.
5. Having weighed all statements against each other, calculate the number of "points" which have been awarded to each option (i.e. the number of times each option "won"). . This will give an overall ranking for all the options.

Sample form:

Option 1 Option 2	Option 1 Option 3	Option 1 Option 4	Option 1 Option 5	Option 1 =
	Option 2 Option 3	Option 2 Option 4	Option 2 Option 5	Option 2 =
		Option 3 Option 4	Option 3 Option 5	Option 3 =
			Option 4 Option 5	Option 4 =
				Option 5 =

Example 2

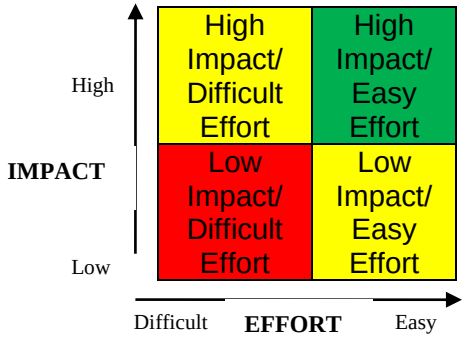
Dot Voting
Dot voting provides a mechanism to organize and prioritize large amounts of data in an equitable way for all the voices on the team to be heard

Instructions:
1. Create a list of agreed upon options, each representing a single idea or thought.
2. Each team member is provided with an equal number of adhesive "dots". The number of dots provided to each team member is discretionary (typically 5-10).
3. Team members will then "vote" with their dots by affixing them to the highest-impact options. They are free to apply all dots to a single item or distribute them across multiple elements. Voting is done silently so as to not influence the voters.
4. Once the voting has been completed by all participants, the team will then be able to identify high-priority options.

Example 3

Impact-Effort Matrix
Impact-Effort Matrix helps assess if an organization can implement proposed solutions by considering effort and cost and the impact and benefit.

Instructions:
1. Finalize and number the options that you want to analyze.
2. Construct an empty diagram with effort required to implement the option on the horizontal axis and impact of the option on the vertical axis, and divide it into four quadrants.
3. Assess the effort needed to implement the option.
4. Assess the impact of each option (consider costs, resources, technology, skills, etc.) on achieving the target state.
5. Place the option number in the diagram according to the assessments. Use a symbol, color, or label to identify each possible option.
6. Options falling into the upper right-hand quadrant will yield the best return on investments.



APPENDIX B: MY HEALTH TEAM (MyHT) ENGAGEMENT GUIDE

A Template Guide on How to Stimulate Engagement of and Expansion to New MyHT Partners

*The future of primary care involves system reform to achieve **one integrated system**, characterized by accessible, comprehensive, and continuous care. In this vision, patients will identify **Home Clinics** as their "home base" for the timely provision and coordination of all their health needs, while **MyHTs** act as the central points for coordinating core functions of patients' care, by making connections to wider program areas and services in their "health neighbourhood"*

***Purpose:** Expansion to other partners is a key step in this process as* partners benefit from networking to support and leverage one another based on each other's availability, service area, interests, skills, and expertise, *based on patients' unique needs and preferences. This Engagement Resource is intended to guide MyHTs through the brainstorming and decision-making process related to identifying and engaging new signatory and non-signatory stakeholders in the expansion of their MyHT.*

***Audience:** MyHT Steering Committee*

A. CURRENT MyHT: List all current stakeholders engaged in the MyHT (formally or informally)

FEE-FOR-SERVICE CLINICS	
Clinic Name	Contact Information

FIRST NATION HEALTH CENTRE **First Nations have their own health authorities. It is suggested that the conversation about involvement in a MyHT should happen at that level.* ** Please note the special considerations that must be given when using provincial dollars to provide health services on First Nation communities.*	
Clinic Name	Contact Information

TEACHING CLINICS	
Clinic Name	Contact Information

RHA CLINICS/ PROGRAMS/ SERVICES

Mental Health
- *Children and Youth*
- *Adults*
- *Seniors*

Quick Care Clinics
Home Care
Renal Program
Access Centres

Community Health Clinics
- *Women's Clinics,*
- *Teen Clinics*
- *Trans Clinic/STBBI*

Women's Health
Personal Care Homes
Cancer Care
Mobile Clinics

Health Promotion Healthy Living
- *Healthy Babies*
- *Healthy Families*
- *Healthy Teens*
- *Healthy Seniors*
- *Healthy Sexuality*
- *Healthy Communities*

Nutrition and Food Services
- *Craving Change*
- *Diabetes and Heart Health*

Family Doctor Finder
Pharmacy
Get Better Together
Midwifery
Healthy Together Now

Name	Contact Information

COMMUNITY ORGANIZATIONS (e.g., MB HIV Program, Addictions Foundation of Manitoba)	
Name	Contact Information

B. FUTURE MyHT: List all potential stakeholders that could be engaged formally and informally with the MyHT.

In this brainstorming exercise, please consider:

a) ***Your Current Services and Service Plan:*** Determine what other clinics, groups, organizations in the community are delivering services or doing work in areas that might address the needs of the MyHT's vulnerable population groups or high system users.

Disabilities (e.g., developmental, intellectual)	*Inner-city or high crime areas*	*Family Planning*
Sexually Transmitted and Blood Borne Infections	*First Nations, Métis and Inuit populations*	*Frail elderly*
Immigrants or New Canadians (under 5 years)	*Rural and/or remote locations*	*Transient workers*
Mental illness (e.g., mood & anxiety disorders)	*Low Socioeconomic Status*	*Chronic conditions*
Homeless	*Substance use*	*Other:*

b) ***Snowball effect:*** ask potential partners who THEY know in the community who is delivering related services.

FEE-FOR-SERVICE CLINICS

Clinic Name	Address	Phone	Contacts

FIRST NATION HEALTH CENTRE

**First Nations have their own health authorities. It is suggested that the conversation about involvement in a MyHT should happen at that level.*
** Please note the special considerations that must be given when using provincial dollars to provide health services on First Nation communities*

Clinic Name	Contact Information
	First Nation Health Authority

TEACHING CLINICS

Clinic Name	Contact Information

RHA CLINICS/ PROGRAMS/ SERVICES

Mental Health
- *Children and Youth*
- *Adults*
- *Seniors*

Quick Care Clinics
Home Care
Renal Program
Access Centres

Community Health Clinics
- *Women's Clinics,*
- *Teen Clinics*
- *Trans Clinic/STBBI*

Women's Health
Personal Care Homes
Cancer Care
Mobile Clinics

Health Promotion Healthy Living
- *Healthy Babies*
- *Healthy Families*
- *Healthy Teens*
- *Healthy Seniors*
- *Healthy Sexuality*
- *Healthy Communities*

Nutrition and Food Services
- *Craving Change*
- *Diabetes and Heart Health*

Family Doctor Finder
Pharmacy
Get Better Together
Midwifery
Healthy Together Now

Name	Contact Information

COMMUNITY ORGANIZATIONS (e.g., MB HIV Program, Addictions Foundation of Manitoba)

Name	Contact Information

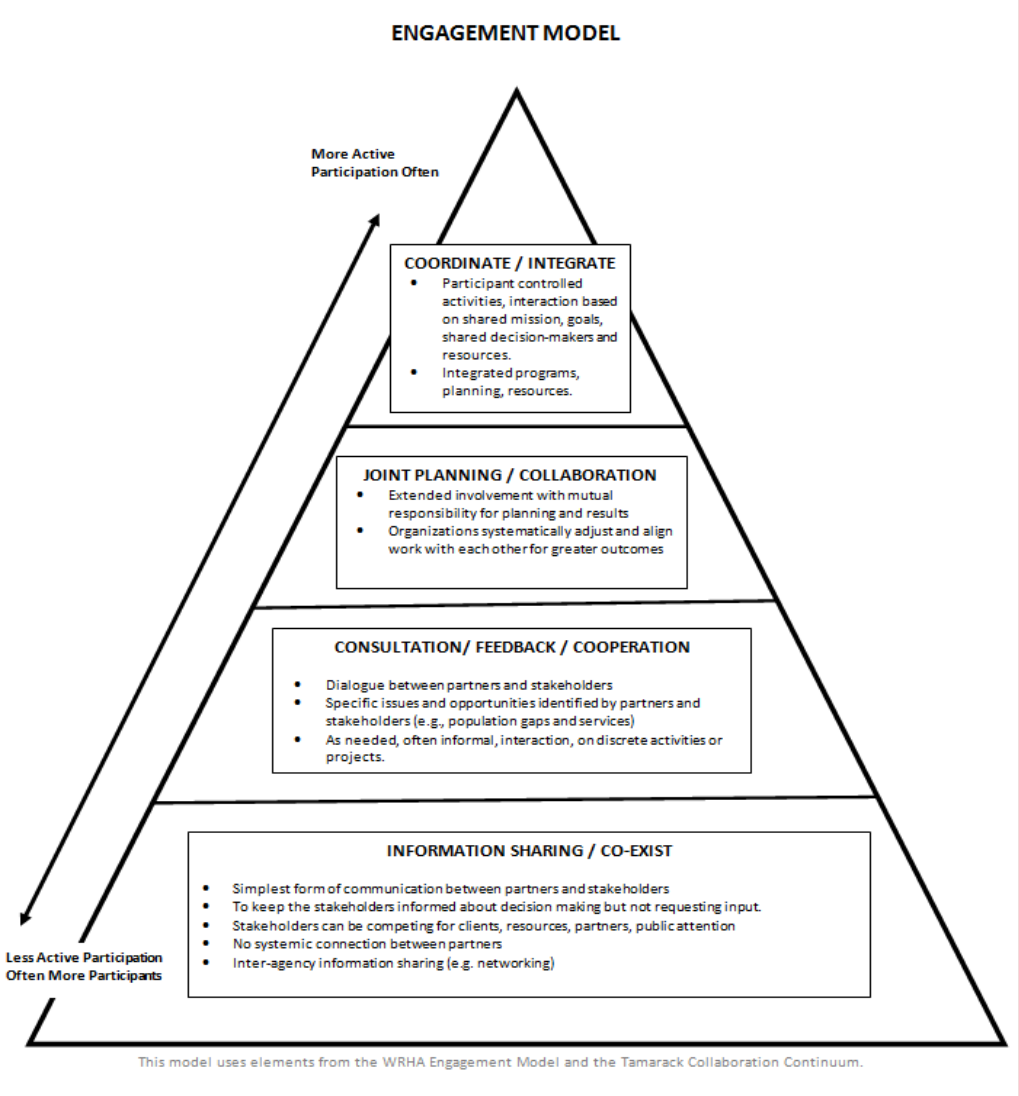
OTHER

Name	Contact Information

C. READINESS FOR ENGAGEMENT: Describe and rate the current level of engagement for each potential stakeholder listed in Section B.

This model was developed by the WRHA to serve as a tool to identify the collaboration levels of each MyHT partner. As an activity, the MyHT must consider how engaged each potential partner is with the MyHT currently to determine where they would be placed on the Engagement Model (with less active stakeholders on the bottom and more active stakeholders near the top). Factors considered in their engagement include the clinic's/program's/service provider's:

- Knowledge of Community Resources
- Knowledge of MyHT
- Home Clinic Registration Status
- Integration of services with existing resources/PHC initiatives (e.g., cross reference who is involved with ITDI, Shared-Care, Family Doctor Finder, ITDI, PIN, …)
- Established dialogue or information sharing with the MyHT
- Established interest in joining the MyHT (Hostile? On the fence? Desire to "watch and wait" prior to intense engagement?)
- Level of Involvement of Physician Lead
- Consultation basis (e.g., Steering Committee)



Name (Potential stakeholders listed in Section B)	Current Level of Engagement	Rate (1 to 10) • 1 (Not Involved/ Not Interested) • 10 (Very Involved/ Ready to Join MyHT)

D. DESIRED LEVEL OF ENGAGEMENT: Using the same model in Section C, please describe and rate the desired level of engagement for each potential partner listed in Section B.

* Note: not all partners may have the same desired outcome or degree of engagement. While it may be beneficial to join together as formal partners (where they would sign on to the agreement), others would benefit from working more closely together via informal partnerships.

Name (Potential partners listed in Section B)	Desired Level of Engagement	Rate (1 to 10) • 1 (Less Critical) • 10 (Very Critical to the Future of the MyHT)

E. NEXT STEPS: Please consider strategies to engage and attain the desired level of involvement for those prospective partners rated as a 7+in Section D.

* Note: next steps and strategies to increase engagement will be dependent on the group's readiness to engage (See engagement model in Section C).

Low/Moderate Current Engagement	High Level of Current Engagement

• **Increase awareness of:**
  ○ RHA Vision and Services
  ○ Home Clinic
  ○ MyHT Resources (including how MyHTs utilize these services and benefit from working with allied health professionals)
• Begin **information sharing** (e.g., share minutes, practice profile – Appendix i)
• Reach out and **introduce yourself** by email.
• Physicians share **peer-to-peer success stories** of what the MyHT has done for their practice.
• **Build on existing connections** (e.g., Primary Care Connector/Family Doctor Finder, Shared Care Worker) for introductions or to share information about the MyHT vision.
• **DO NOT** discuss details of deliverables and agreement, as this can be overwhelming.
	• **Set up joint meetings,** or allow them to come to steering committee meetings to hear more and to engage in information exchange.
	• Go to early adopters and **invite to join the MyHT**
	• **Build relationship and trust**
	• **Discuss**
	  - **Benefits of joining a MyHT**, such as building partnerships within the community that lead to increased visibility of the clinic and greater access to community resources; in addition to potential cost and time savings from implementing efficiency improvements.
	  - **Their needs**
	  - **Common goals & Opportunities to work together** by identifying community resources that the MyHT has access to – either from community resources or other FFS practices - that can be leveraged).
	• Consider **system enablers** to support further integration (Appendix ii)
	• Add to **MyHT Expansion Plan/Service Plan**
	• **Get buy-in** re: RHA Vision & MyHT expansion
	• **DO NOT** discuss details of deliverables and agreement, as this will come later.

* Note: Further work will be required to identify the full range of resources/services required to support service delivery as the Teams evolve and delivery models shift to accommodate the growing capacity of the MyHT's.
* Note: Although your priority might be in one area, you must engage people as they are ready to come forward.

Name (Potential partners rated 7+ in Section D)	Describe Strategies/ Next Steps	Timeline	Lead

SAMPLE EXCEL SPREADSHEET

**Please complete the following spreadsheet using information collected from the Engagement Resource template. This will provide a concise overview of data to allow for a user-friendly analysis and tracking of progress.*

Contact Information	Current Level of Engagement	Rate 1 to 10 - 1 (Not Involved/ Not Interested) - 10 (Very Involved/ Ready to Join MyHT)	Desired Level of Engagement	Rate 1 to 10 - 1 Less Critical) - 10 (Very Critical to the Future of the MyHT)	Strategies/ Next Steps	Timelines	Lead

KEY POINTS

- Shared models and interventions allow for more than one clinic to benefit from a service, and should be implemented where possible.
- All types of partners should be considered, as each brings their particular area of expertise to the network.
- How to engage each partner will vary depending on their readiness to engage (based criteria such as their current relationship with the MyHT, involvement in provincial initiatives and willingness/ability to engage in an interprofessional teams).
- The degree of engagement can vary by partner. While it might make sense to pursue a formal partnership with one organization (e.g., MyHT signatory partner), others may be better suited as informal partners, where they can leverage services from one another but don't necessarily need to be involved in the strategic planning and governance of the MyHT.
- Start by engaging those that have demonstrated signs of readiness.
- In all cases, **it is highly recommended NOT to** discuss details of **specific MyHT** deliverables and agreement in the initial steps of engagement. Initial stages of engagement should focus on increasing awareness, discussing one another's needs and goals, trust building and discussing potential opportunities for collaboration.

ADDITIONAL RESOURCES

- [WRHA Collaborative Care Website & Powerpoint]
- [2017 MHSAL Service Coordination Framework] http://www.gov.mb.ca/health/primarycare/providers/docs/sc_framework.pdf
- WRHA. (2016). Engagement Model as Evaluation Tool. [Engagement Model.pdf]

APPENDIX i. PRACTICE PROFILE: Include all site information for the potential partners and their specialties listed in Section B.

This will enhance awareness of resources, trigger further conversation with the clinics around "who is in the clinic," "what they do" etc. and to support new prospective members in understanding how the MyHT will help to meet their needs and to understand where they can fit in/assist in building a stronger network.

ALL PROVIDERS PARTICIPATING IN THE PRIMARY CARE INITIATIVES: role and EFT

Full Name	ITDI	MyHT	Role	EFT	Details and starting date at this clinic

PARTICIPATING PROVIDERS: Gender, Age, and Years of Practice

Providers	Gender	Age						Total years of practice
	M / F	*20-30*	*30-40*	*40-50*	*50-60*	*60-70*	*70-80*	

TYPE OF PRACTICE/PROVIDER: (e.g. Solo, partners, association, contract, group, ownership, etc…)

ALL STAFF SUPPORTING PARTICIPATING PROVIDERS:

EMR

Do you have an EMR? (Y/N)	Vendor	How long has been in place?	Did you obtain your EMR through the provincial EMR Adoption Program? (Y/N)	Have you ever submitted data extracts to MB Health? (Y/N)	Can you provide a name of an IT contact person for your clinic?

OTHER RELEVANT INFORMATION:	

APPENDIX ii. SYSTEM ENABLERS

* Note, system enablers represent to factors within the system, which would help to facilitate successful; system integration with the MyHT.

THEMES	DESCRIBED	EXAMPLES
E-Tools	Increasing and optimizing the use of interoperable, efficient, and effective technologies, equipment or products to enable standardized information documentation and sharing.	- Electronic Medical Records (EMR); EMR Pathways; eChart; Patient portals; Health Links; eReferrals; Centralized Repositories, and other Digital Health System Solutions.
Culture	A culture supportive of service coordination standards and leading practices.	- Designated leadership and team members that are committed to service coordination principles, functions, and goals; - Promotion of patient engagement through public access and understanding of information, services, and resources available to them (e.g., Care plans, patient portals, patient reported outcome measures) - Leveraging others' expertise and sharing lessons learned (e.g., MyHTs; Daily Huddles; Manitoba Peer-to-Peer Network and Peer Supporters). - Change management if necessary
Role Clarity	Facilitating alignment and widespread awareness of scopes of practice, information on resources and services, as well as role clarity amongst partners to promote an understanding of existing programs and services, how to connect, and encouraging their use as part of usual practice.	Interprofessional education/training/team-building opportunities or resources re: - Practice profiles, goals and objectives, core features and enablers etc. (e.g., education, toolkit) - How partners foresee sharing resources and services across the MyHT in a way that benefits all parties and optimizes on economies of scale. - Who to call for questions re: system navigation (e.g., Primary Care Connectors; Health Links).
Standardize	Formalizing agreed-upon partnerships, agreements, expectations, and responsibilities amongst partners.	Implementing standards, leading practices, policies, procedures, agreements, protocols, guidelines, processes, pathways, and/or workflow maps, such as those related to: - Accreditation Standards - Roles and activities; - Processes to identify the appropriate resources; - Clinic support and resource sharing; - Physician remuneration (e.g., CCM Tariff); - Communication and information sharing (e.g., Primary Care Working Group form development process) - Legislation, policies, and initiatives supportive of service coordination (e.g., MyHTs; Home Clinics); or - Documentation, monitoring, and evaluation.
System Efficiencies	Analyze whether services are being delivered, and system workflow is being carried-out, in the most cost-effective, cost-efficient, and sustainable way.	Engaging in practice or organizational improvement processes, such as: - Advanced Access - LEAN management - Plan-Do-Study-Act

APPENDIX C: BUDGET SUMMARY TEMPLATE

List ALL items associated with each funding category from your complete list of activities and the corresponding amount and percent of total budget.

	YEAR 3 EXPENSES										
			Y3 Operational Budget ($675 K)			*Y2 Carry Over*	*Other Resources ($ Amount; P/V; In kind)*			*Total*	
	FTE	Class.	Ongoing Expenses	One-time Expenses	Total Ongoing ($675 K)	One-time Carry Over Expenses	RHA	FFS	Com Org	**TOTAL** All P3 Expenses (i.e., ongoing, carry-over, other)	Comments
Direct Service											
					$0.00					$0.00	
					$0.00					$0.00	
					$0.00					$0.00	
					$0.00					$0.00	
					$0.00					$0.00	
					$0.00					$0.00	
Sub-Total	0.0		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
Clinic Support											
					$0.00					$0.00	
					$0.00					$0.00	
					$0.00					$0.00	
					$0.00					$0.00	
					$0.00					$0.00	
					$0.00					$0.00	
Sub-Total			$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
Admin/ Other Expenses											
					$0.00					$0.00	
					$0.00					$0.00	
					$0.00					$0.00	
					$0.00					$0.00	
Sub-Total			$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
	TOTAL:		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	

Unallocated Funds in Priority 3	
Carry Forward From Priority 2	
Unallocated Ongoing Funds in Priority 3	

MyHT:

Date:

	Actual		**Budget**				**Budget**				
	Priority 1 ($525 K)		**Priority 2 ($600 K)**				**Priority 3 ($675 K)**				
Funding Category	$ Amount (ongoing & one-time)	Percentage of $525 K (%)	$ Amount (ongoing & one-time)	Percentage of $600 K (%)	Other $$ (e.g., p/v)	Total (e.g., ongoing, one-time)	$ Amount (ongoing & one-time)	Percentage of $675K (%)	One-time Carry Over Expenses	Other $$ (e.g., p/v)	Total (e.g., ongoing, one-time)
Direct Service	$0.00	0.00%	$0.00	0.00%	$0.00	$0.00	$0.00	0.00%	$0.00	$0.00	$0.00
Clinic Support	$0.00	0.00%	$0.00	0.00%	$0.00	$0.00	$0.00	0.00%	$0.00	$0.00	$0.00
Administration	$0.00	0.00%	$0.00	0.00%	$0.00	$0.00	$0.00	0.00%	$0.00	$0.00	$0.00
Phy leadership/ Engagement	$0.00	0.00%	$0.00	0.00%	$0.00	$0.00	$0.00	0.00%	$0.00	$0.00	$0.00
Total	**$0.00**	**0.00%**	**$0.00**	**0.00%**	**$0.00**	**$0.00**	**$0.00**	**0.00%**	**$0.00**	**$0.00**	**$0.00**

Progress Towards 80/20			
	Priority 1	**Priority 2**	**Priority 3**
Direct Service	0.00%	0.00%	0.00%
General Operations	0.00%	0.00%	0.00%

* Please add columns based on the number of years spent completing each respective priorit