HEALTH LINKS

Community of Practice; Coordinated Care Planning Process Series

STEP ONE:
‘IDENTIFYING Patients’ for Care Coordination

September 9, 2015
PARTICIPATING IN THE WEBINAR

• This webinar is being recorded.

• ALL participants will be muted (to reduce background noise). You can access your webinar options via the orange arrow button.

• **During the discussion portion**, please use the ‘raise your hand’ feature to indicate that you would like to speak.

• If you would like to submit a question or comment at any time, please use chat box feature.
WEBINAR PANEL

HEALTH QUALITY ONTARIO (HQO)

• Sandie Seaman, Manager, QI and Spread
• Jennifer Wraight, Quality Improvement Specialist, QI and Spread
• Stacey Bar-Ziv, Team Lead, QI Best Practice Networks

GUEST PANELISTS

• Joshua Hambleton, Project Manager, Arnprior Region and Ottawa West Health Link (within Champlain LHIN)
• Tory Merritt, Project Manager, North York Central Health Link (within Central LHIN)
• Laurel Hoard, Quality Improvement & Implementation Facilitator, Quinte Health Link (within South East LHIN)
• Lisa Priest, Director, North East Toronto Health Link (within Toronto Central LHIN)
• Rosalyn Gambell, Manager Health Links, Telehomecare, Medicine Out Patient Services, and GEM nurses. South Simcoe Northern York Region Health Link (within Central LHIN)
• Ana MacPherson, Clinical Coordinator, South Simcoe and Northern York Region Health Link (within Central LHIN)
• Agnes Gibson, Project Manager, Central East LHIN Project Management Office (within Central East LHIN)
• Jodeme Goldhar, Chief Strategy Officer and Senior Director, Strategy and Planning, Toronto Central Community Care Access Centre

ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE

• Jade Woodruffe, Senior Advisor, MOHLTC. Capacity, Planning and Priorities Branch.
WEBINAR OBJECTIVES

Purpose
To review the current provincial landscape for Health Links, and facilitate Health Link to Health Link learning and discussion.

Specifically, this webinar will aim to:
To provide a brief review of:

- Health Links Target Population; as per the Ministry of Health and Long-Term Care
- The general practices and processes that have evolved in Health Links across the province, so far.

Connect the Health Link Community to:
- Take a deeper dive into selected practices relating to the process step ‘Coordinated Care Planning- Identifying the Patient’
- Share and learn from one another
THE COORDINATED CARE PLANNING PROCESS
IN PROGRESS

- Emerged organically through the work of early adopters and emerging Health Links.
- Not mandatory - yet most Health Links have adopted or adapted some or all of these steps into their processes.
- Continues to evolve.

Identify Patients
“Recognize that I may benefit from care coordination”

Engage the Patient
“Engage me to participate in care coordination”

Initial Interview
“Let me share what is important to me and what my goals are”

Care Conference
“Together, we develop my coordinated care plan”

Maintenance and Transitions
“I work with my team to meet my goals and my team stays connected”
COMMON TARGET POPULATION:

Advanced Health Links Standardization:
Common Target Population

A Common Process for Identifying Health Links Population:

• Staying with the 5% - Health Links will continue to focus on Ontario’s Complex Patients.
• The common process will include:
  o Patients with four or more chronic/high cost conditions, including a focus on mental health and addictions conditions, palliative patients, and the frail elderly.
  o Economic characteristics (low income, median household income, government transfers as a proportion of income, unemployment).
  o Social determinants (housing, living alone, language, immigration, community and social services etc.).
• Focus on adaptation of care planning for vulnerable populations (MHA, Frail/elderly and Palliative) to support strategic focus.

*Please refer to the original slide deck for details
SCAN of HEALTH LINKS PRACTICES
re: the “Identify Patients” step

Data driven case finding:
1) Electronic Medical Record (EMR)
2) Health Record/ Caseload analysis

Clinical level identification:
1) Emergency Department (ED) (e.g. on admission to ED, discharge from ED)
2) Hospital (e.g. via admission/ contact with specific programs, etc.)
3) Community Care Access Centre (CCAC) (e.g. by caseload, triggered by involvement in certain programs, etc.)
4) Primary Care (e.g. by Primary Care Providers, allied health programs or providers, etc.)
5) Community- other

May use:
- Standardized tools (LACE, HARP, etc.)
- Prompt questions (does this person keep you up at night?)
- Clinical judgment
- Etc.
ARNPRIOR REGION AND OTTAWA WEST
HEALTH LINK

Joshua Hambleton, Project Manager,
Arnprior Region and Ottawa West Health Link (within Champlain LHIN)
Tailoring to Sub-local Environments

Geographic Hubs of Activity

- **Arnprior** – small rural hospital with GPs covering inpatients (FHT attached to hospital)

- **CARP** – Family Health Team & Community Paramedic Program

- **Kanata** – Community Hospital, large FHT, many community agencies (limited connections)
Evolving Identification Strategies

- **Unattached** eReferrals via Hospital EHR
  - Discharge RN for admitted patients
  - GEM for ER visits
  - CCAC for community identification

- **Retirement Home**
  - Care Director identifies Health Link residents

- **FHT** Lead Physician Invite
  - Existing FHT resource introduces Health Links to referred complex patients & liaises with AROW team
LESSONS LEARNED

• Don’t trust the data - need to confirm current fit/situation of patient with someone who know them (GP, Care Mgr, etc)

• Build multi-level commitment – leadership buy-in does not translate into frontline support

• Cultivate champions – work with the willing and highlight successes to build peer relations
CONTACT INFO

How do I find out more about AROW?

Contact:

Joshua Hambleton
Project Manager, AROW Health Link
613-818-0809
jhambleton@arnpriorhealth.ca
NORTH YORK CENTRAL HEALTH LINK

Tory Merritt, Project Manager, North York Central Health Link (within Central LHIN)
PATIENTS ARE IDENTIFIED IN REAL-TIME

**Inpatients**
- LACE score of 8 or higher
- 2 or more admissions in ~6 months
- 2 or more co-morbidities

**ED**
- 5 or more ED visits in last 12 months
- MH or suspicion of MH diagnosis

**Primary Care and Outpatient Clinics**
- PRA score of 50% or higher

**Community**
- Admission within last 90 days
- 2 or more co-morbidities
- DIVERT score of 6
LACE focuses on risk of re-admission

LACE identifies patients at risk of readmission within 30 days by considering:
- Length of Stay
- Acuity
- Co-morbidities
- ED visits
LESSONS LEARNED

• Criteria should be simple + straightforward
• Criteria should not be too restrictive
• Patients who meet criteria may not need Health Links
• Patients who need Health Links may not be flagged through criteria
  • Lack of caregiver or capabilities of caregiver
  • Social Determinants of Health
CONTACT INFO

Tory Merritt
Manager, Strategy & Health Links
North York General Hospital
416-756-6000 x 4182
Tory.Merritt@nygh.on.ca
QUINTE HEALTH LINK

Laurel Hoard, Quality Improvement & Implementation Facilitator, Quinte Health Link (within the South East LHIN)
HealthLinks in the South East LHIN

- 7 Health Links cover 100% of our geography
- Primary care led
- QI approach over the last 2 years
Evolution of Interventions to Identify Individuals for Quinte HL Involvement

• **Test 1:** list of high cost patients from hospitals given to Primary Care

• **Test 2:** Stanford Tool – 4 questions for Primary Care Providers:
  1. Which patients do you worry about and keep you up at night?
  2. Which patients do you think are headed for a hospital admission?
  3. Who do you think is on a downward trajectory?
  4. For whom would you like to have extra eyes and ears in the home?

• **Test 3:** Hospital Patient Flow Coordinators identify people with 4+ chronic conditions and some social determinants of health challenges

• **Planning Test 4:** SHIIP & LACE
LESSONS LEARNED

♦ Complex patients have unmet health AND social needs. Some have simple wishes.

♦ We need to consider the potential to make an impact when identifying people. Some will require more, some may require less and some we may not be able to help through HLs.

♦ The Care Coordinator role seems most effective when embedded within the primary care team.

♦ We scaled up too quickly focusing on numbers rather than processes and engagement, especially provider engagement.
CONTACT INFO

Mary Woodman
Project Manager, Quinte Health Link
woodmanm@bqwchc.com

Laurel Hoard
Quality Improvement and Implementation Facilitator, SE LHIN
Laurel.hoard@lhins.on.ca

Cheryl Chapman
Senior Consultant, Design and Implementation, SE LHIN
Cheryl.chapman@lhins.on.ca
NORTH EAST TORONTO HEALTH LINK

Lisa Priest, Director,  
North East Toronto Health Link (within Toronto Central LHIN)
About the Practice

The North East Toronto Health Link identifies patients in real-time, using an innovative information management system (Better Care) and this objective measure: how many times they visited the emergency department or have been admitted over the past six months. This approach means all patients who hit the trigger have an equal opportunity to be engaged, enrolled and participate in the care planning process, creating equitable access for all patients to a basket of enhanced services: a virtual community care team.

- **Algorithm**: 4 visits to the emergency department OR 3 inpatient visits in six months to Sunnybrook Health Sciences Centre who live in the Health Link geography as validated by a clinical advisory committee. *Frailty algorithm embedded.

- **Patient engagement embedded in the clinical program**: Patients are engaged and enrolled in real-time by a core care team based at Sunnybrook after hitting the trigger (registration)

- **Privacy**: Health Link patients say ‘yes,’ ‘no, not now’ or ‘not ever’ to care planning and being flagged.

- **Data-sharing** and participatory agreements are required among partners.
Patient profiles:

**Palliative:**
- Cancer patients

**Frail seniors:**
Those biologically older “60”
- Living alone, isolated
- Falls
- “property rich” but financially living on the margins

**Complex under 60:**
- Pain
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure

**Mental Health & Addictions:**
- Severe persistent mental illness
- Repeated overdose
- Addictions
- Personality disorders
- Mental health conditions

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**ED Statistics - North East Toronto**

**ED Visits during 6 months from 11/30/2014 to 5/31/2015**

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<td>Total # ED Visits:</td>
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<tr>
<td>Total Unique Patients:</td>
<td>71</td>
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<tr>
<td>Minimum # ED Visits:</td>
<td>4</td>
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<tr>
<td>Maximum # ED Visits:</td>
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<td>Average # ED Visits:</td>
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**Triage Level (%)**

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<tr>
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**Age**

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<td>Visits - Age &lt; 65 yrs</td>
<td>56.6%</td>
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<tr>
<td>Visits - Age 65-74 yrs</td>
<td>12.9%</td>
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<tr>
<td>Visits - Age 75+</td>
<td>30.5%</td>
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LESSONS LEARNED

- **Change Management**: Creating a care team and buy in from partners on helping “our patients” who live in “our geography.”

- **Blending work**: Need to blend work and deliverables for those doing care planning to make it sustainable.

- **Accountability**: Identifying and notifying alone are not enough. Health Link partners report back at Advisory meetings on care planning progress.

- **Patient Engagement**: Patients evaluate the program for improvements based on questions developed by Health Link Patients’ Advisory Council; patient engagement requires a strong governance structure.

- **Program Evaluation**: Health Links patients evaluate the program.

- **Data Sharing**: Agreements are critical to safely sharing information.
Contact information:

Lisa Priest  
Director & Patient Engagement Lead  
North East Toronto Health Link  
Sunnybrook Health Sciences Centre  
2075 Bayview Avenue  
Toronto, ON  M4N 3M5  
Phone: (416) 480-6100  Ext. 87711  
Fax: (416) 480-7834  
Email: lisa.priest@sunnybrook.ca
SOUTH SIMCOE AND NORTH YORK REGION HEALTH LINK

Rosalyn Gambell, Manager Health Links, Telehomecare, Medicine Out Patient Services, and GEM nurses. South Simcoe Northern York Region Health Link (within Central LHIN)

Ana MacPherson, Clinical Coordinator, South Simcoe and Northern York Region Health Link (within Central LHIN)
ABOUT THE PRACTICE

- For this process to work, we need buy-in from frontline CCAC Coordinator support on initiating the CCP
  - Education on criteria
  - Referral process needs to be simple
  - Authorship and Viewership of CCP should be made simple
ONGOING ENGAGEMENT & PROGRAM PROMOTION TO KEY PROVIDERS

- To include Education and Awareness:
  - Of Health Links Patient Criteria (LACE Score/ HL Checklist)
  - Health Links Process

- Community Support Rounds –introduced
  - Case discussions
    - Coordinated Care
    - Social Determinants
    - Mental Health
LESSONS LEARNED

- Establish relationship with community partners
- Buy in from frontline staff
- Ongoing awareness or follow up:
  - HL criteria
  - HL successes and benefits to referring source/potential referrers
- Future…
  - HL Target Population expansion to include Social Determinants of Health, MHA, low SES, frail elderly population.
CONTACT INFO

Ana MacPherson, MASc, RRT, CRE, CTE  
Clinical Coordinator, South Simcoe Northern York Region, HL  
amacpherson@southlakeregional.org  
905-895-4521 ext 5326
CENTRAL EAST LHIN REGION
HEALTH LINKS

Agnes Gibson, Project Manager,
Central East LHIN Project Management Office (within Central East LHIN)
ABOUT THE CENTRAL EAST LHIN HEALTH LINKS

• Central East LHIN established a central Project Management Office to support all 7 Health Links in the region.

• Strong focus on leveraging existing resources in place, by embedding the CCP process into existing programs that serve patients with complex issues.

• Vision for implementation is a shared model for leading patients through the CCP Process (multiple providers across multiple organizations will be able to lead patients through the CCP process).
ABOUT THE PRACTICE
Patient level identification processes

Example:

ABC Organization- XYZ Program

- Existing program already in place.
- Providers supporting patients with complex health and wellness issues already in place.
- Mechanisms for identifying patients with complex health and wellness issues in place (whole program or streams within a program, etc.)

To identify patients that may benefit from care coordination:

- Build on existing mechanisms in place (vary across organizations/ programs).

For example, if a program has a ‘general’ stream, and an ‘intensive case management’ stream, those requiring intensive case management automatically become patients identified as potential Health Links/ Care Coordination candidates.
LESSONS LEARNED

Benefits of approach:
• Minimal change to processes for Health Link partner organizations
• Identifies patient *where they are*, at a time when they may benefit from Coordinated Care Planning.
• Providers can continue to provide service to a complex patient population they are already working with, and have developed expertise around.

Limitations of approach:
• Patients selected may not match the description of the ‘Target Population’ exactly.  *Next steps; additional ‘lens’ may need to be added.*
• May not capture patients who are not yet connected with appropriate providers. *Next steps: may explore additional approaches to identifying patients, to create multi-pronged approach.*
THANK YOU!

Agnes Gibson, Project Manager, Central East Health Links
905-430-3308 Ext. 5854
Agnes.Gibson@ce.ccac-ont.ca

Andrea Smith, Project Manager, Central East Health Links
905-430-3308 Ext. 5912
AndreaM.Smith@ce.ccac-ont.ca
ONE CLIENT- ONE TEAM

Jodeme Goldhar, MSW, MHSc
Chief Strategy Officer, Senior Director, Strategy and Planning,
Toronto Central CCAC
ONE CLIENT - ONE TEAM

Advancing an Integrated System of Care
Driving Transformation &
Health System Integration Enabled Through Health Links

Presenter:
Jodeme Goldhar, MSW, MHSc
Chief Strategy Officer
Senior Director, Strategy and Planning
Adjunct Lecturer, University of Toronto, Institute of Health Policy, Management and Evaluation
President, University of Toronto, Institute of Health Policy, Management and Evaluation, Society of Graduates

Co-Developed with:
Philip Ellison, MD MBA CCFP FCFP
Fidani Chair, Improvement and Innovation
Program Director, Quality Improvement
Primary Care LHIN Lead
Primary Care Advisor, TC CCAC
Aim

Supporting populations with complex needs with better care at home in their communities, utilizing existing resources

Our Approach: One Client: One Team

For the client/family
• Seamless care
• One team approach

For the providers
• One team approach
• Built around what's most important for client and family needs

"I was so surprised the nurse already knew what the doctor had planned and that the care team speaks every day. It makes it easier for me as the caregiver: I don’t have to make sure everyone has all of the information and it makes me more confident in the care team."

Caregiver
A framework for Implementation: Care Planning Matrix

A framework to guide discussion on the alignment of resources, human and technology, to the needs of clients/patients, in their circle of care – in primary care and in the community.
How To Utilize Human/IT Resources within Primary and Community Care Organizations based on Clients' Needs and Risks

**Complex Care Plan Management**
- Provided by Dedicated Clinicians
- Need – Professional Development
- IM/IT Project – Decision Assist Tools

**Clinical Services Coordination**
- Provided by Primary Care Teams and Community Health Agencies
- Need – Customer management
- IM/IT Project – Document Management

**Social and Community Services Collaboration**
- Provided with Community Health
- Need – Build Relationships
- IM/IT Project – Database Development

**Self-Management Support**
- Facilitated by Care Providers
- Need – Toolkits, apps
- IM/IT Project – Registry and Portal

Clients’ Resource Availabilities
- Social Capital, Health Literacy

High

Clinical Intensive
- “Management” (Highest Risk)
- Clients

Low

Losing
- IADLs

Normal
- Cognition & Mobility
Lessons from the Integration Strategy

It’s not complicated!

Pause...

• How does the patient and caregiver experience this
• Build meaningful relationships
• Value others contributions and perspectives
• Build ‘leaderful’ teams

But don’t stop!

• Don’t wait for complex or perfect solutions
• Incrementally build toward excellence
• Find comfort in ambiguity
• Leverage and align with system enablers
• Using and implementing the framework
Contact Information

Jodeme Goldhar, MSW, MHSc
Chief Strategy Officer
Senior Director, Strategy and Planning
Adjunct Lecturer, University of Toronto, Institute of Health Policy, Management and Evaluation
President, University of Toronto, Institute of Health Policy, Management and Evaluation, Society of Graduates
Toronto Central CCAC
250 Dundas St. W Suite 305
Phone: (416) 217-3820 ext. 2515
Fax: (416) 506-0124
Email: jodeme.goldhar@toronto.ccac-ont.ca

Philip Ellison, MD MBA CCFP FCFP
Fidani Chair, Improvement and Innovation
Program Director, Quality Improvement
Primary Care LHIN Lead
Primary Care Advisor, TC CCAC
Associate Professor
Family and Community Medicine
500 University Ave., 3-339, Toronto M5G 1V7
Phone 416 978 3213 Fax 416 978 8179
Email: phil.ellison@utoronto.ca
@1CareQIMD
DISCUSSION

- Please use the ‘raise your hand’ feature to indicate that you would like to speak.

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HEALTH LINK COMMUNITY OF PRACTICE: WEBINAR SERIES

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<td>Wednesday September 9, 2015</td>
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<td>Webinar 2: CCP – Engage the Patient</td>
<td>Tuesday September 22, 2015</td>
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<td>Webinar 3: CCP – Initial Interview</td>
<td>Wednesday October 7, 2015</td>
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<td>Wednesday October 21, 2015</td>
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<td>Webinar 5: CCP - Maintenance and Transitions</td>
<td>Tuesday November 10, 2015</td>
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AND ALSO…

| Health Quality Transformation, Health Links Lunch and Learn Abstract Session | Wednesday October 14, 2015 |
October 14, 2015
Metro Toronto Convention Centre- South Building

REGISTRATION IS NOW OPEN

www.hqontario.ca

Lunch and Learn Session:
‘Improving Care for Patients With Complex Conditions’
# REGIONAL QUALITY IMPROVEMENT TEAMS

<table>
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<th>QI Specialists</th>
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</tr>
<tr>
<td>LHINs: ESC, SW, WW, HNHB</td>
<td>Gina DeSouza</td>
<td><a href="mailto:Gina.DeSouza@hqontario.ca">Gina.DeSouza@hqontario.ca</a></td>
<td>289-218-8216</td>
</tr>
<tr>
<td></td>
<td>Linda Hebel</td>
<td><a href="mailto:Linda.Hebel@hqontario.ca">Linda.Hebel@hqontario.ca</a></td>
<td>519-318-6578</td>
</tr>
<tr>
<td></td>
<td>Julie Nicholls</td>
<td><a href="mailto:Julie.Nicholls@hqontario.ca">Julie.Nicholls@hqontario.ca</a></td>
<td>519-502-5164</td>
</tr>
<tr>
<td><strong>Central Ontario</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LHINs: MH, CW, TC, Central</td>
<td>Kamal Babrah</td>
<td><a href="mailto:Kamal.Babrah@hqontario.ca">Kamal.Babrah@hqontario.ca</a></td>
<td>416-571-7668</td>
</tr>
<tr>
<td></td>
<td>Laurie Hurley</td>
<td><a href="mailto:Laurie.Hurley@hqontario.ca">Laurie.Hurley@hqontario.ca</a></td>
<td>416-722-0735</td>
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<td><strong>Eastern Ontario</strong></td>
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<tr>
<td>LHINs: CE, SE, Champlain</td>
<td>Monique LeBrun</td>
<td><a href="mailto:Monique.LeBrun@hqontario.ca">Monique.LeBrun@hqontario.ca</a></td>
<td>613-293-6843</td>
</tr>
<tr>
<td></td>
<td>Dana Summers</td>
<td><a href="mailto:Dana.Summers@hqontario.ca">Dana.Summers@hqontario.ca</a></td>
<td>613-327-1427</td>
</tr>
<tr>
<td></td>
<td>Jennifer Wraith</td>
<td><a href="mailto:Jennifer.Wraith@hqontario.ca">Jennifer.Wraith@hqontario.ca</a></td>
<td>647-237-0098</td>
</tr>
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<td><strong>Northern Ontario</strong></td>
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<tr>
<td>LHINs: NSM, NE, NW</td>
<td>Tracy Howson</td>
<td><a href="mailto:Tracy.Howson@hqontario.ca">Tracy.Howson@hqontario.ca</a></td>
<td>705-927-3165</td>
</tr>
<tr>
<td></td>
<td>Sue Jones</td>
<td><a href="mailto:Sue.Jones@hqontario.ca">Sue.Jones@hqontario.ca</a></td>
<td>647-523-7510</td>
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**Central & Eastern Ontario**
- **Manager:** Sandie Seaman  
  [Sandie.Seaman@hqontario.ca](mailto:Sandie.Seaman@hqontario.ca)  
  416-508-3115
- **Team Lead:** Kim Kinder  
  [Kim.Kinder@hqontario.ca](mailto:Kim.Kinder@hqontario.ca)  
  647-521-5109

**Northern & Southern Ontario**
- **Manager:** Shannon Brett  
  [Shannon.Brett@hqontario.ca](mailto:Shannon.Brett@hqontario.ca)  
  1-866-623-6868 x299
- **Team Lead:** Stacey Bar-Ziv  
  [Stacey.Bar-Ziv@hqontario.ca](mailto:Stacey.Bar-Ziv@hqontario.ca)  
  416-938-1182