Alliance for Healthier Communities
*Advancing Health Equity in Ontario*

# Neighbourhood Health Homes – The Hub and Spoke Model

## Introduction

This case example illustrates how a Hub and Spoke model referred to as the Neighbourhood Health Home enables delivery of comprehensive primary health care that is team-based, and is centered around increasing access, attachment, population health and health equity. The model consists of a Hub (team-based primary health care organization) and Spokes (primary care providers and groups who are not directly part of a team, but who have access to it). In this collaborative Hub-and-Spoke model, primary care providers and interprofessional teams collaborate to meet local needs of the communities they serve. This paper describes a model that exemplifies the Neighbourhood Health Home and highlights the components and lessons learned since its inception.

## The Concept: Neighbourhood Health Home

The neighbourhood health home model is deeply rooted in health equity and ensures that every person will have attachment to primary care and barrier-free access to an interprofessional primary care team. This model focusses on connecting primary care practices across neighbourhoods to operate as an integrated system of care without disrupting independent organizations. This mode, if deployed across Ontario, will facilitate increased attachment rates and the draw down from the Health Care Connect list.

# Key Components

## Interprofessional, collaborative primary health care

The Hub (*i.e., team-based organization*) within this model provides ongoing primary care as well as social and community-based supports tailored to the needs of people who experience barriers to care. The Hub organizations is the lead agency for health promotion and preventive care, as well as social and community supports. The Hub acts as the central coordinating body with the Spokes (*i.e., all primary care providers in the community*) having access to the services and supports provided by the Hub, ensuring that care is coordinated and seamless. Essentially, the Hub is a one-stop shop where individuals can be screened, supported, and assessed for all their needs, such as primary care, interprofessional resources and/or population health programming. Depending on the patient's health complexity and care needs, they may continue as a patient of the Hub or be transitioned to one of the Spokes. By ensuring patients are attached and connected to the right type of care, this creates a long-term relationship that facilitates stability and continuity of care.

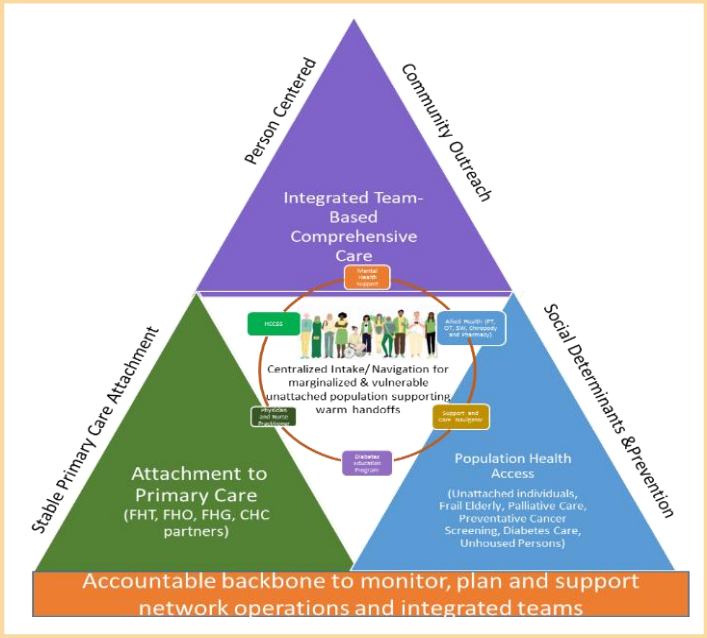


*Figure 1: The Neighbourhood Network Model*

A key feature of this model is that it builds primary care capacity and increases access to interprofessional, team-based primary care by pooling and sharing resources among partners while ensuring care is coordinated and seamless. Not all patient needs may require a visit with their primary care provider and in fact, may be better addressed by another team member. By having the appropriate interprofessional resources attached to primary care, patients would receive the right care from the right person while maintaining a close patient-provider relationship. In short, this model is specifically designed to increase the system's capacity to attach patients to primary care, provide wrap-around team-based care, and reduce administrative burden. All participating physicians and groups signed memorandums of understanding that outlined the expectations and increased numbers of people that they would attach.

## Community governance and engagement

The Hub organization is community-governed (see Alliance Community Governance paper). This ensures that the community has an explicit voice in decision-making and accountability. Meaningful community governance goes beyond having a board comprised of community members; the voice of the community is centred in decision-making across the organization. This ensures that organizations orient and tailor services to meet ongoing and changing population health needs.

## Population-based approach and a strong data foundation

The Neighbourhood Health Home embraces a population-based approach through a robust data infrastructure that includes data collection from all interprofessional teams and providers. Sociodemographic and race-based data is collected for all patients, as well as encounter-level details for every provider/staff interaction recorded in an electronic medical record (EMR).

A key enabler within the Hub is a centralized intake process involving a single point of contact, initial assessment, personalized care planning and navigation to primary care. This process allows for a common assessment that all primary care partners have agreed upon and trust as valid. This helps to maintain a consistent understanding of population needs for primary care attachment and to do population segmentation using standardized data. This also allows more efficient communication and information sharing between providers. Ideally the Hub will be the Health Information Custodian (HIC) for the region to facilitate intake from the Health Care Connect list. On a broader level, population health-based assessments is also used to identify care needs for unattached population in the neighbourhood network and advocate for more interprofessional team care members.

## A focus on equity and the determinants of health

The Neighborhood Health Home is guided by the Model of Health and Wellbeing which is a comprehensive model of primary care that reinforces the importance of applying both a health equity lens and population health approach to supporting the health and wellbeing of marginalized people and communities. As such, team-based organizations support both clinical and social determinants and provide low-barrier access to primary care resources for unattached, marginalized and complex patients. Developing patient personas is one method that they used to understand the marginalized populations that are being targeted and they barriers they face in receiving and accessing care.

## Accountability and efficiency

The Hub provides education and professional development; oversight of standards, policies and practices, including documentation of care delivery; Electronic Medical Record systems, technology, IT infrastructure; as well as administrative support for collecting data and understanding measures of attachment and access. These back-office supports are a key support provided by the Hub. Alignment on such policies contributes to efficient processes and increased accountability. The Hub, as the central fund holder, can support reporting and accountability and work with the primary care network to consider resource allocation. The Hub provides accountability metrics to funders and communities. Mechanisms for

accountability include benchmarking reports and performance measures, which are publicly shared. These support transparency, oversight, and meaningful comparisons with peer organizations to inform improvement. Quality Improvement coaches are leveraged to support ongoing improvement and action.

# Key Steps to Implementing the Neighbourhood Health Home Model

## Identifying unmet needs

Once the region (or population) / was chosen, it was vital to understand and identify what the unmet needs of the community are. This included collecting information from data sources such as public health, Ontario Health Team Profiles, community focus groups, etc. on:

- the unattachment rate
- what primary care resources are available (*e.g.,* proportion of solo primary care practitioners, the number of family physicians per 100,000 residents, etc.)
- sociodemographic information of the community (*e.g. race and ethnicity, income, education, etc.)*
- the prevalence of medium to high comorbidities,
- the prevalence of mental health diagnosis, and
- Other relevant data

## Getting buy-in from partners

The Neighbourhood Health Model is successful when the primary care partners in the community ware fully on board. This can be achieved using research to show how attaching interprofessional support to primary care can increase the supply of primary care visits, and how this model would serve and meet the needs of patients. For example, by increasing access to social work, the network could free up approximately 500 primary care visits for other needs.

Additionally, it should be emphasized that this model recognizes the importance of attachment and makes it easier for patients to be transferred between primary health care providers and organizations in the community ensuring that people have access to the most appropriate level of care. For example, a patient who has been receiving care from the Hub for complex health and social needs may become stabilized over time and no longer need such intensive supports. In this model, the Hub has an opportunity to transfer this patient to a nearby neighbourhood primary care partner (*i.e., one of the Spokes).* Likewise, a primary care partner or one of the Spokes has a patient whose needs become more complex, can reach out to the Hub and ask to have that patient transferred there.

### Building trust to create a common vision

A key element to developing strong relationships between partners is making space for conversations to explore community health needs and each organization's willingness to work in a new way. It is important for all partners to understand that implementing this model is not a takeover but a move towards deeper collaboration and meaningful implementation of integrated care.

To build trust between partners, the Hub can leverage their expertise in operations, clinical governance, and knowledge of the community to foster an environment for their partners to come together, receive support, and trust that this model could work. Once trust is built, partners within model can come together to envision a model (see Figure 1 for an example) that is innovative, efficient and cost effective, builds on the strengths of each organization without foreseeing a major integration, and prioritises meeting the needs of the community.

One active Hub is measuring and evaluating the success of the collaboration and to-date the teams are showing increased trust, willingness to collaborate and a shared vision.

## Impact and Next Steps

Implementing this model has produced strong and positive results in a short period of time including increased shared vision, trust and collaboration as well as thousands of new people being attached to primary care When primary care providers work together and share resources, patients have a greater chance in becoming attached to primary care and access to interprofessional team members.