Concept Paper: TeamCare

Alliance for Healthier Communities
Advancing Health Equity in Ontario

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TeamCare offers **"seamless care optimizing patient experience" by anchoring** interprofessional team based care to all primary care providers in Ontario. The result will ensure more seamless transitions of care for patients; enhance experience of providers; and reduce hallway health care.

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Please note

While it is several years old now, the TeamCare concept continues to evolve, and we are committed to iterative co-design with our partners. We have had input from a variety of people to date and welcome ongoing feedback. For a list of all reviewers please see Appendix D.

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Executive Summary | Concept Paper: TeamCare

Primary Care as the Foundation

A strong primary care foundation is essential for an integrated health care system; however, in Ontario there are gaps in this foundation due to unequal access to interprofessional teams. With the move towards Ontario Health Teams we have the perfect opportunity to strengthen this foundation by ensuring that 100% of primary care providers (PCPs) have streamlined access to interprofessional teams and home and community services. This strong foundation, in keeping with the principles of the Patient-Centered Medical Home, will advance the quadruple aim. By better connecting care, it will improve the patient experience, better connect care, and ultimately improve health outcomes and reduce costs. This concept paper is being iteratively written and includes multiple viewpoints. It will involve partnerships and engagement from each region and the solution and success will belong to all of us.

The Opportunity

In Ontario, over 50% of physicianss do not have access to interprofessional teams. Over the last few years, innovative solutions have been created that ensure PCPs have increased access to interprofessional teams, social care, and community supports. These solutions created collaborations between primary care providers, specifically physicians without access to teams and the interprofessional teams themselves. Despite this progress, additional funding is required to spread and scale team-based care across Ontario. TeamCare is a viable solution to do this. TeamCare leverages a proof-of-concept that has demonstrated success and continued demand. Various primary care models have successfully expanded access to teams and social programming through innovation and collaborative partnerships.

The concept of TeamCare envisions streamlined collaboration with a network of interprofessional teams for all PCPs focused on their patients who need teams most. Care coordination and system navigation are integral to this solution and require that existing home and community care coordinators work to full scope and are embedded within primary care settings.

The Solution

The TeamCare prototype has been built on an evidence-informed premise that primary care providers need streamlined access to interprofessional teams for their clinically and socially complex patients. Primary care providers want a single, centralized point of access that is easy to use and ensures on-going coordination and collaboration. It has been conceptualized using a tested platform which ensures streamlined access to the professionals and partnerships required by PCPs to support their patients. Care coordination and system navigation are built in, ensuring access to essential clinical and social services, seamless transitions, and ongoing coordination and collaboration. Interprofessional teams that include health promotion, mental health and addiction agencies, and other community supports give people access to the health and social services they need.

We envision that each TeamCare site will be established with local care providers using co-design methodology and ongoing collaboration. Each site will be guided by a local advisory/steering committee that incorporates local primary care providers, primary care networks, patient advisors, and senior managers from the partnering organizations. These partnering organizations may include local hospitals, social service organizations, and/or mental health agencies. Each TeamCare setting will be unique. Their differences will reflect existing capacity in the region and which partners come to the table. However, all TeamCare settings will be locally co-designed and incorporate continuous quality improvement, and they will all embody the quadruple aim.

The TeamCare Concept

Aim

To reduce pressures on hallway healthcare and physicians without access to team-based care by innovating a new pathway for horizontal and vertical service integration and collaboration that will substantively improve the patient's health care experience and outcomes.

Approach

To support 100% of primary care primary care providers through a shared network of interprofessional teams.

The challenge

Interprofessional teams working in collaboration with primary care providers are key to keeping complex patients out of hospital hallways, but in Ontario more than 50% of primary care physicians cannot access team supports[1].

Increasing numbers of people living in Ontario have social and medical complexities that would be better addressed by interprofessional primary health care teams and through social programming.[2,3] Without access to teams, people with complex social and medical needs flood hospitals and add pressure to "hallway healthcare." They also add pressure to primary care providers (PCPs). Nearly 5000 physicians across the province lack access to an interprofessional team, and thus they lack infrastructure to manage care for patients living with social and medical complexity. These "second tier" physicians without access to teams are overburdened in caring for this group of complex patients on their own.

The prevalence of patients with multi-morbidities in primary care settings is increasing, and with it the clinical burden faced by PCPs.[4] One common limitation in primary care, cited by both patients and providers, is that there is insufficient time and structure to address multiple interacting conditions within a typical 15-minute appointment.[5]

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1 Schultz, Susan E., and Richard H. Glazier. "Identification of Physicians Providing Comprehensive Primary Care in Ontario: a Retrospective Analysis Using Linked Administrative Data." CMAJ Open, vol. 5, no. 4, 2017.

2 Carrier, E., & Reschovsky, J. Expectations outpace reality: physicians use of care management tools for patients with chronic conditions. Washington (DC): Centre for Studying Health System Change; 2009. Issue Brief No. 129.

3 Strumph, E., Ammi, M., Diop, M., Fiset-Laniel, J., Tousignant, P. The impact of team-based primary care on health services utilization and costs: Quebec's family medicine groups. Journal of Health Economics 55 (2017) 76-94.

4 Fortin M, Hudon C, Haggerty J, van den Akker M, Almirall J. Prevalence estimates of multimorbidity: a comparative study of two sources. BMC Health Serv Res. 2010;10(1):111. doi:10.1186/1472-6963-10-111.

5 Adler, H, Patel, A et: al: Factors associated with healthcare- related frustrations among adults with

There is substantive evidence that frequent users of acute care services (emergency department (ED) and hospital admission and readmissions) are challenged in meeting the social determinants of health (SDOH). For primary care, the "people who keep us up at night" often lack stable housing, food security or the funds to cover needed prescriptions which only complicate their struggles with chronic disease.[6] A team of providers with a range of expertise is required to meet these various needs effectively.

Where possible, care coordination and system navigation should be located within primary care. This will ensure that all people receive effective, seamless, and continuous transitions between providers and across the health and social service system.

The opportunity

A strong primary care foundation is essential for Ontario Health Teams. Ensuring that all PCPs have access to interprofessional teams, home and community services, and other supports will improve patient experience, better connect care, and ultimately improve health outcomes and reduce costs. This concept is reflected in the 10 pillars of the Patient-Centered Medical Home (see Appendix A).[7]

The solution

TeamCare will provide streamlined access to a network of interprofessional teams for all PCPs, focused on the patients who need teams most.

- A trained and supervised network of interprofessional teams across the province will link 100% of PCPs to team-based care for their patients who need it most. This could include PCPS who work with long-term care homes.
- A social prescribing link worker[8] and partnerships with community and social service partners will be embedded within the interprofessional team model. This will ensure clinical pathways for health care—supporting, non-medical services
- Home and community care coordinators will be embedded or co- located with

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chronic conditions. Patient Educ Couns. 2017 Jun;100(6):1185-1193. doi: 10.1016/j.pec.2016.12.033. Epub 2017 Jan 6.

[6] Rosella, L., Fitzpatrick, T., Wodchis, W. Calzavara, A., Manson, H., Goel, V. High-cost health care users in Ontario, Canada: demographic, socio- economic, and health status characteristics. BMC Health Services Research. 201414:532.

[7] Patients Medical Home. Every family practice across Canada offers the medical care that Canadians want – seamless care that is centred on individual patient's needs, within their community, throughout every stage of life, and integrated with other health services. https:// patientsmedicalhome.ca/ Accessed. Feb 6, 2019.

[8] Link workers/system navigators are based in primary care organizations. They support people to develop and achieve personal health and wellbeing goals by engaging with social and community resources. Kiely B, Clyne B, Boland F, *et al* 2020. Link workers providing social prescribing and health and social care coordination for people with multimorbidity in socially deprived areas (the LinkMM trial): protocol for a pragmatic randomised controlled trial. *BMJ Open* 2021: **11:**e041809. DOI: 10.1136/bmjopen-2020-041809

interprofessional teams to enable seamless care transitions.

- Clinical pathways and service partnerships for interprofessional teams will include home care, acute care, mental health and addictions support, and community and social services. This will ensure people have access to the services they need in a timely, seamless, and coordinated manner.

These resources would be seamlessly connected through a single, centralized point of access that can be digitized. This single point of access will ensure that the model is both patient-centered and provider-enhanced. Partnerships will be established to ensure timely and seamless access to the following:

- Mental health and addictions service delivered beyond the scope of the interprofessional team.
- Home and Community Care to ensure seamless discharge from hospital and care in the home to avoid readmissions.

This solution will be established through on-going collaboration with local care providers, ensuring:

- A centralized single point of access that is convenient for PCPs to use and acts as the scaffold to add locally appropriate services.
- A population-based approach to health care integration that ensures continued quality improvement and aligns with the Institute of Health Care Improvement (IHI) Quadruple Aim: improved patient experience and health care outcomes, reduction in health care costs, and improved health care provider experience.[9]
- A Primary Care lead, rooted in the local community, who can represent PCPs in championing and advocating for seamless and collaborative service delivery.
- A strong advisory council that includes primary care providers PCP and patients.
- Grassroots co-design: PCPs, interprofessional team members and patients are involved in planning and ensuring continual improvement.

[9] WIHI: Moving Upstream to Address the Quadruple Aim. Rishi Manchanda, MD, MPH. December 15, 2016. http://www.ihi.org/resources/Pages/AudioandVideo/WIHI-Moving-Upstream-to-Address-the-Quadruple-Aim.aspx A

The proof-of-concept

"Advancing Access to Team- Based Care" (TeamCare) at 33 sites in more than 40 communities in Ontario serving approximately 1600 primary care physicians.

Right now, many communities across Ontario are already "Advancing Access to Team-Based Care" by directly linking over 1600 physicians without access to teams to team-based care sites – without a new OMA agreement, new governance structures or changes in OHIP billing codes. Physicians are joining with enthusiasm because this program addresses their needs and the needs of their most complex patients. For example, community and physician demand for social prescriptions is increasing exponentially because of the assistance for people who previously were going to their physician for non-medical concerns.

The outcomes

A healthy foundation in primary care and seamless transitions within the health system

Effective primary care engages people to achieve their optimal long-term health and wellbeing, connecting them seamlessly with interprofessional teams, specialist services, and community and social services as required throughout their lives. Population needs-based planning ensures resources are allocated according to the needs of the community and its populations and helps proactively determine risk and ensure that people are receiving the care that they require.[10] Access to team-based care and rapid access to specialists helps strengthen care in the community and in many cases averting the need for acute care services.

Care coordination embedded within primary care is essential to ensure smooth transitions between home and community care and other health and social services when needed.[11, 12] Ensuring that the current Home and Community Care coordinators are working to their full scope of practice and are placed within existing and new team models will ensure that everyone receives the supports they need. This would enable the widely-endorsed Enhancing Community Care for Ontarians (ECCO) model to be

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[10] Agency for Healthcare Research & Quality (2016). Creating Patient-Centred Team-Based Care [White Paper]

[11] Connecting Care Coordination with Primary Care Settings: Guidance Document. Ministry of Health and Long-Term Care. November 2018.

[12] Registered Nurses' Association of Ontario (2014). Enhancing Community Care for Ontarians (ECCO). https://rnao.ca/policy/reports/rnaos-ecco-report-enhancing-community-care-ontarians-%E2%80%93-three-year-plan.

operationalized, so all existing resources in the community can work to their optimal scope of practice. This includes rapid response nurses, care coordination, system navigation and the palliative care program.[12] All existing and new TeamCare sites are ready to integrate Home and Community Care coordinators and system navigators into their team to support everyone in their community, including those rostered to physicians. According to academic leaders, 21st century enhanced primary health care delivery models accomplish the following outcomes[13] :

- Identification of at-risk populations that can be proactively co-managed, supported by functions within the EMR.
- Bi-directional feedback that enhances effective co-management – for example, identifying high-needs patients in the ED who would benefit from team-based services, or providing PCP feedback about hospital bottlenecks and inefficiencies.

The return on investment: *Saving money, reducing hospital visits*

US studies suggest that linking physicians to interprofessional, team-based primary health care yields potential cost savings between $10 and $90 per person, per month. Canadian studies show that it results in an 11% decrease in primary care visits and a 6% decrease in specialist visits[14]. The model advances the quadruple aim: better health outcomes; improved provider morale; decreased inappropriate use of hospitals; and costs alleviated through investment in low-cost upstream solutions.[15]

Attending to the SDOH has demonstrated improvements in patient well-being, self-management, and mental and social health, as well as significant return on investment.[16] A recent systematic review demonstrated positive health and spending outcomes as a result of investments in social and integrated models of health care.[17]

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[13] Hawker, G. Chair's Column: Innovations in Primary-Specialty Care for Complex Medical Patients: The Value of Partnership. University of Toronto Faculty of Medicine. March 6, 2018.

[14] Strumpf, Erin, et al. "The Impact of Team-Based Primary Care on Health Care Services Utilization and Costs: Quebec's Family Medicine Groups." Journal of Health Economics, vol. 55, 2017, pp. 76–94., doi:10.1016/j.jhealeco.2017.06.009.

[15] Reid, R.J., Coleman K, Johnson, E.A, et al. The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. Health Affairs. 2010; 29(5):835-843

Reid, R.J, Fishman P.A, Yu, O, et al. Patient-centred medical home demonstration project: a prospective, quasi-experimental, before and after evaluation. American journal of Managed Care. 2009;15(9):e71-87

[16] Dayson, C., & Bashir, N. The social and economic impact of the Rotherdam Social Prescribing Pilot: Main Evaluation Report. Sheffield Hallam University. Centre for Regional Economic and Social Research. September 2014.

[17] Taylor, L., Tan, A, Coyle, C., Ndumele, C., Rogan, E. et al. Leveraging the Social Determinants of Health: What Works? PLoS One. 2016; 11(8): e0160217.

The scale-up

Every region in Ontario currently has some interprofessional primary health care teams, including CHCs, NPLCs, FHTs, IPHCOs, and CarePoint Health. This existing network can be used to scale up to meet the needs of patients with complex health and social needs.

TeamCare across Ontario: The Possibility

A network of interprofessional teams, seamless care coordination and streamlined access to specialists in partnership with mental health and addictions and community care.

To serve PCPs most clinically and socially complex clients, a province-wide network of new or expanded interprofessional teams is required, as well as a platform that will streamline access, communication and collaboration among PCPs, interprofessional teams, specialists and other service providers. The teams will be employed (where possible) in existing team-based organizations. To support seamless transitions of care, existing home and community care coordinators will be embedded into primary care and the newly created interprofessional teams. Other interprofessional team members can be leveraged from existing provincial programs, such as diabetes, COPD, and regional palliative care supports.

Each site will be co-designed with local PCPs and patients and tailored to community-specific needs. The expanded resources are embedded within the existing team model which ensures existing programs and services can be leveraged. The model for each TeamCare site includes an overarching steering committee, as well as an advisory council that includes patients, physicians and members of the interprofessional team. The team-based model does not require practicing PCPs to forfeit their current practice designations and would be available to PCPs without access to teams. Access to specialists would be available to all primary care physicians including those who work in team-based models such as FHTs and CHCs.

The Emerging Business Case

The Journey so far

TeamCare has expanded rapidly because it meets the needs of patients and those of physicians. Capitalizing on existing opportunities, the program is growing beyond all expectations. TeamCare has expanded patient and physician access to interprofessional teams and to non-clinical programming through social prescribing. It can be scaled up rapidly across the province to ensure 100% of physicians have access.

The concept of the TeamCare model has evolved and expanded over time.

SPiN: SPiN began in the TC LHIN as an outcome of a Health Links initiative in mid-west Toronto to link physicians to services at CHCs. Called SPiN (Solo Physicians in Need), today it provides 100 physicians with access to 16 CHCs with culturally appropriate services for their most complex clients. The CHCs that participated in SPiN did not receive any additional resources so capacity has been an on-going issue; however, they continue to work on optimizing access.

PINOT: In other LHINs, SPiN became known as PINOT (Patients in Need of Teams). With MOHLTC's support, four LHINs were funded to each hire four facilitators and a project manager to connect physicians to existing services in CHCs.

TeamCare: In 2018-19, the MOHLTC extended funding to expand access to team-based care and many interprofessional teams put forward proposals to implement TeamCare models. Today the majority of the programs are called "TeamCare." In total, 12 CHCs and one CFHT offer the full model of team-based care and access to their services. Many others offer access to their existing services but have not been funded to offer supplemental team-based care.

Today, all the above initiatives provide over 1600 primary care physicians access to CHC services and/or expanded team-based care. With this small pilot, the program is expected to reach more than 2000 physicians and 23,000 patients, with more than 120,000 visits to interprofessional providers (see Appendix B for list of lead organizations).

Why this is Working

- TeamCare provides an interprofessional team that physicians do not have to manage. This is provided at no cost to their patients, many of whom could not afford to pay for such services.
- Physicians have said that they need team-based support for their socially and clinically complex patients – especially those who need more services than the PCP can offer. Physicians worry about these patients but lack capacity to maintain up-to-date knowledge of available community services, and time needed to properly explain and refer patients to them.

- The collaborative model ensures physicians continue as the "most responsible provider" and are routinely kept informed about services and progress (the circle of support for patients and their physicians with ongoing communication and care planning).
- Many patients need social supports, due to loneliness or isolation, compounding their challenges in managing health conditions. Social prescribing has shown immediate benefits for patients and PCPs.
- TeamCare frees up physicians without access to teams time to see more patients. We have already seen that once they have access to interprofessional health and social care, patients see their physicians less often.
- TeamCare has built-in, on-going measurement and quality improvement to ensure PCPs and patients' needs are met.
- PCPs are involved in co-design and on-going development to ensure continual improvement

Case Examples[18]

Windsor TeamCare

- Windsor TeamCare is a unique partnership with a Community FHT and CMHA with an embedded CHC. It has a focus on mild to moderate mental health and addictions, layered with other issues. It addresses hallway health care and leverages existing investments in MH&A.
- The Windsor team includes: 1 nurse practitioner, 0.5 pharmacist, 1 nurse/health promoter, 3 social workers, 2 addiction counsellors, 1 registered practical nurse, 2 medical secretaries, 1 kinesiologist, 1 physiotherapist, 0.5 respiratory therapist, 0.5 dietitian, and 1 onsite director.
- Windsor also has a LHIN-funded clinical care coordinator.
- As of 2019, it links over 80 physicians to the team, with the goal of 100 physicians when fully operational. In four months, they have had over 800 referrals.

[18] These case examples reflect the state of TeamCare as of the original writing of this concept paper in December 2019. Specific details in the data may have changed since then and will be updated in a future iteration.

Black Creek TeamCare

- Black Creek TeamCare has an expanded team consisting of: 3.5 NPs, 1 RN, 1 RPN, 2 health system navigators, 1 bilingual community health worker, 1 dietitian, 2 chiropodists, 4 social workers, 2 physiotherapists, 2 medical secretaries and 1.5 receptionists.
- In each sub-region, the following services are offered to physicians without access to teams: health system navigation, chiropody, physiotherapy, nutrition counselling, mental health and addictions counselling, retinal screening, diabetes management, COPD management, lactation consultation, midwifery, and exercise prescription. In addition, all existing Black Creek programs are also being offered.
- Within six months of implementation, over 100 physicians have referred approximately 1000 patients in one sub-region.
- The teams are working with physicians in both sub-regions to forge relationships with community and co-create a program that supports PHCs' patients' needs.
- Approximately 40% of the referrals are for mental health and social services (addressing the SDOH such as housing, legal, employment, etc). The physicians and team engage in regular, ongoing communication to ensure collaboration and trust.
- Black Creek has partnered with the local hospital which identifies unattached patients or those who require support navigating their transitions from hospital. The formalized partnership places a TeamCare health system navigator in the emergency room to provide services where and when people need them.

Social Prescribing

- A structured clinical pathway to link complex clients with complementary non-medical supports.
- Under social prescribing in a TeamCare model, a physician whose client has complex needs makes a referral to the team. A social prescribing link worker or navigator then links the client with appropriate resources, either within the team or with community partners, and supports them in accessing these resources.
- Using client- and community-centred design thinking, participating centres identify all that they do in terms of non-clinical interventions, build a structured clinical pathway, and track the impact of this work on health outcomes through a robust data collection and evaluation framework.
- Positive evaluation results demonstrating decreased loneliness, more social supports, clients feeling that they could manage their own health and fewer visits to primary care providers for issues better dealt with elsewhere.
- Increased community and client involvement in their own care – clinicians and clients are co- creating solutions with the community to ensure the needs are being heard and met appropriately.

The evaluation

Preliminary evaluation data from 2019 indicates that the clients referred by non-team physicians are more clinically and socially complex compared to other patients on their roster. Provider and client experience has been all positive and further evaluation is underway. On-going measurement includes client/caregiver experience, access, quality of life, and health outcomes. In addition, data are being collected from physicians and interprofessional teams measuring team climate, collaboration, trust and overall experience. Utilization data is being reviewed on an on-going basis to ensure continued quality improvement including communication, times to referral and satisfaction. Site-specific data are also demonstrating promising results.

Data from 2019 demonstrate continual improvement in patient volume, new referrals and wait times. Approximately half the clients each month are new to the Team Model. The average processing time for a team-based referral is less than half a day and communication back to the physician is on average 2.5 days after the appointment. Satisfaction ratings among patients to-date are over 95% and 100% for physicians. The majority of physicians (75%) are satisfied with the degree of collaboration and communication between themselves and the interprofessional teams.

The feedback

Recipients of care, teams, and non-team physicians find value in TeamCare and are demanding more.

Physician feedback

> "This (interprofessional team) funding is important to our community because it will give us the opportunity to improve the quality of life for people living in the area and has the potential to make a significant impact on the burden of disease in patients and their families. We as health care providers can see this investment in the short and long term, lead to outcomes that will result in **reduced** Emergency Room visits to hospitals and enhanced quality of life for all members of our community"
>
> – *TeamCare Referring Physician*

> "I have referred many of my patients to multiple programs at TeamCare, and there has been a universal positive response. The services they provide, include social work, counselling, physio, and a host of others are invaluable to the management of so many issues we encounter in family practice. Unfortunately, without a program like TeamCare, these essential services are often inaccessible to many patients because of cost. I am grateful for the work they are doing, and I think we are fortunate to have a TeamCare program in our city."
>
> – *TeamCare Referring Physician*

"Social prescribing reflects a change in how the medical community views health and wellness and the role that doctors and other health practitioners can play. And I believe the reason why it's important is because we forget that health is not only about physical well-being and mental well-being, **it's also about** social well-being."

- Social Prescribing Physician

"So long in healthcare we've said, 'you're a diabetic,' or, 'you're a this or that,' and **we don't want people to be defined by their illness**.... We know that when people feel like they belong, they have a place to be, they have a purpose in their life and they're not illness or diagnoses focused – their health actually gets better."

- Social Prescribing Physician

Patient feedback

"I have benefited greatly and it has **changed my life; I am now a productive** member of the community"

- Recipient of TeamCare

"In the end I am really happy I ended up going, the person I talked to was so nice. It felt very human. It was really helpful coming here. I feel like I definitely have a different outlook on so many things. I find myself listening to people more and even trying to help my friends who may be struggling like I was before. I am going to continue to access groups and services at the CHC.

- Recipient of TeamCare

"I've spent the last six years not working and not being out because of health reasons, but now I can go [to the Community Health Centre], **I'm comfortable** there. [Volunteering as part of social prescribing] helps me just as much as it helps them."

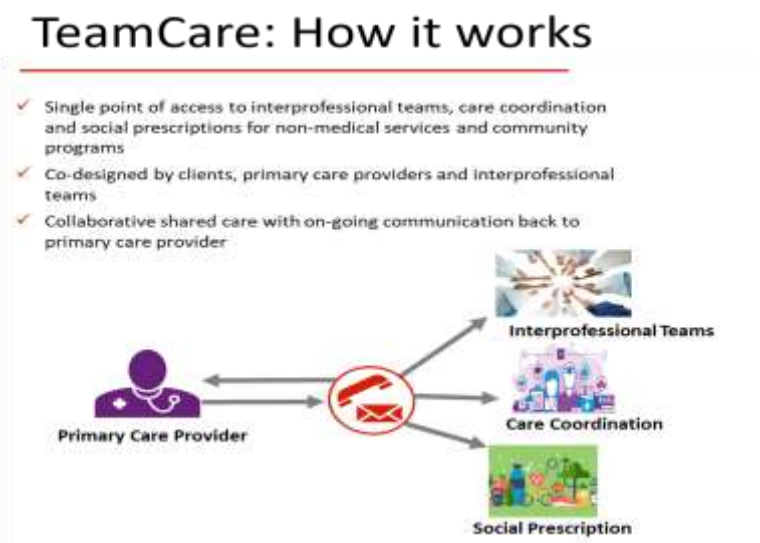
- Recipient of Social Prescription

- Ontario health-care providers explore social prescriptions to help patients heal without drugs (Globe & Mail)
- Niagara agencies collaborating on mental health and addiction issues (Welland Tribune, 29 April 2019)
- TeamCare Centre opens doors to Windsor community, offers 'upstream approach' to patient care (CBC)
- Team Care launched to improve health care in the city (TB News, 08 February 2019).

The Journey Continues

Prototype: TeamCare

We are proposing an evidence-informed model that has been designed using the work-to-date as building blocks. This model will ensure that 100% of PCPs have access to interprofessional teams for their clinically and socially complex clients as well as access to home and community coordinators, social prescribing, and access to specialists for concerns that are not easily addressed in a busy primary care office. This model is aligned to and an enabler of the Patient Medical Home.



Here's how it works

CONTACT: The PCP contacts 'TeamCare' by phone or digitally, outlining the patient's needs and suggests potential directions. The PCP remains the patient's primary care provider at all times.

CONNECTION: The nurse navigator contacts the patient directly and conducts an intake assessment. This might start with an interprofessional provider or care coordination, but could also include other options such as community kitchens, walking groups and self-management groups. The nurse navigator as well as other providers involved loop back to the PCP maintaining a tight connection as part of the circle of care.

COLLABORATION: Ongoing collaboration between the patient, the PCP, the team and the partners happens throughout the patient's journey. Points of communication are built into, but are not limited to, the point of connection with nurse navigator, after the first visit, upon any changes or new services on the care plan, and upon completion of TeamCare participation.

Each model may look different based on community differences and co-design. However a core team to support TeamCare should include:

- Navigator/Intake (often a RN)
- Home and Community Care Coordinator
- Social Workers
- Dietitians
- Chiropody
- Administrative support

- System navigator/link worker for social prescribing
- Other team members based on community population need, such as a physiotherapist, a pharmacist, addictions/harm-reduction workers, etc.
- In addition to the core team, partnerships will be created with mental health and addictions, homecare, and other social and community supports.
- The model has been successful to date when hospital senior management appreciates the potential for proactive ambulatory care that mitigates ED visits and offers a platform to improve the effectiveness and efficiency of services, especially during transitions of care.
- If TeamCare is established in an existing team-based model, all existing resources and programs will be leveraged and available to PCPs in the community, thereby maximizing the service options, such as diabetes education, health promotion and community programming, as well as access to additional interprofessional team members.
- It will be critical that the home and community care coordinators are embedded/co-located with each team and are working to full scope of practice. This is aligned with the primary outcome of the Care Coordination Guidance Document which states that people in Ontario should be able to access person-centred care coordination in their primary care setting.[19],[20]
- An advisory council will be established for each TeamCare that will include PCPs and patient representation. Each TeamCare will identify a PCP champion. This will ensure continual co-design and on-going quality improvement through real-time metrics and robust evaluation. Ensuring PCP involvement in every step will also keep PCPs engaged and encourage continued collaboration.
- Strong connections with the PCPs are essential to ensure patients are transitioned back to their regular provider when they have achieved their goals. This is a key enabler of capacity and flow and all communication modalities will be streamlined as much as possible.

See Appendix C for answers to frequently asked questions about TeamCare in practice.

[19] Connecting Care Coordination with Primary Care Settings: Guidance Document. Ministry of Health and Long-Term Care. November 2018.

[20] Registered Nurses' Association of Ontario (2014). Enhancing Community Care for Ontarians (ECCO). https://rnao.ca/policy/reports/rnaos-ecco-report-enhancing-community-care-ontarians-%E2%80%93-three-year-plan. Access March 29, 2019.

The Need

- Across Ontario, 4728 physicians currently lack access to teams.[21] The biggest need is for mental health and addictions support.
- Based on surveys done in 2019, on average 241 people per physician, or about 20% of rostered clients per physician, would require access to team-based care.[22,23] (this may have increased)
- A Ministry priority is to embed existing home and community care coordinators into primary care organizations including IPHCOs, CHCs, FHTs and NPLCs.[24]
- Existing TeamCare sites are ready to include Home and Community care coordination/system navigators into their service delivery model enabling PCPs ready access to care coordination. All new teams will be expected to have home and community care coordinators/system navigators.

The return

- This model shifts care further upstream to less expensive, more appropriate team members and results in positive health outcomes, fewer emergency room visits, and better discharge care, resulting in lower costs.
- US studies suggest that linking physicians to team-based care has potential cost savings between $10 and $90 a month per person[25], and Canadian studies show an 11% decrease in primary care visits and a 6% decrease in specialist visits.[26]
- UK studies of social prescribing have demonstrated a 14 to 23% reduction in hospital and emergency referrals and a return on investment of 50 pence for every pound invested.[27]

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[21] Schultz, Susan E., and Richard H. Glazier. "Identification of Physicians Providing Comprehensive Primary Care in Ontario: a Retrospective Analysis Using Linked Administrative Data." CMAJ Open, vol. 5, no. 4, 2017.

[22] Calculation based on number of CHC physicians, FHO physicians who are part of a FHT and the physicians that have access to AA-TC subtracted from the number of comprehensive primary care physicians in Ontario

[23] Schultz, S. & Glazier, R. "Identification of Physicians Providing Comprehensive Primary Care in Ontario: a Retrospective Analysis Using Linked Administrative Data." CMAJ Open, vol. 5, no. 4, 2017

[24] Connecting Care Coordination with Primary Care Settings: Guidance Document. Ministry of Health and Long-Term Care. November 2018.

[25] Agency for Healthcare Research & Quality (2016). Creating Patient Centred Team-Based Care [White Paper]

[26] Strumpf, Erin, et al. "The Impact of Team-Based Primary Care on Health Care Services Utilization and Costs: Quebec's Family Medicine Groups." Journal of Health Economics, vol. 55, 2017, pp. 76–94., doi:10.1016/j.jhealeco.2017.06.009.

[27] Dayson C & Bashir N. (2014). The Social and Economic Impact of the Rotherham Social Prescribing Pilot. Retrieved from King's Fund website :

- Research shows that this model advances the quadruple aim: improved patient experiences, cost savings with more appropriate upstream providers, improved health and system outcomes, and high-functioning teams featuring improved professional satisfaction, a higher level of physician work-life satisfaction, and a lower level of provider burnout.[28]

Next Steps

It is exciting to see the enthusiasm for the TeamCare concept. Health system partners are coalescing around this constructive and practical solution to strengthen primary care, anchored in the patient's medical home model and enhanced through accessed to team-based care.

The work on the ground developing these models continues. We are learning from front-line providers, both PCPs and team members, as they share their insights and experiences.

We are also learning with each consultation and feedback from a wide range of reviewers to date. We welcome and will review all your feedback. To acknowledge your input and thoughts, we will include you in the future list of reviewers (see Appendix D for full list of reviewers).

Please send all feedback to Jennifer Rayner, PhD: Jennifer.rayner@allianceON.org.

https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf

[28] Reid, R.J., Coleman K, Johnson, E.A, et al. The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. Health Affairs. 2010; 29(5):835-843

Appendix A: Alignment to Patient Medical Home

TeamCare: Consistent with PMH

Pillars	Description
Administrative and funding supports the PCMH	TeamCare will have levels of oversight and involvement that include participation by primary care, patients and team-based providers. Local health authorities have funded the model. Population-based approach assumes that care will be provided for a community of people.
Appropriate infrastructure in	Registered PCPs able to access virtual team-based care via EMR and other supported technology.
Connected Care	Centralized access to virtual team that is co-located at the hospital or community hub for a range of health and social services.
Accessible Care	Rapid response time – same day **in real time** to specialist and community services Further work needs to be done re: 24/7 care to PCP
Community adaptiveness and social accountability	Platform links PCPs and their patients to experts trained to support vulnerable populations. Intake assessments identify clinical and social needs and services are planned using a holistic approach – including access to a broad range of services including social and clinical programming. Patients are included in the co-design and oversight of all TeamCare models ensuring services are responsive to community needs.
Comprehensive team-based care with family MD lead	Platform links PCPs and their patients to a suite of services across the continuum ranging from interprofessional teams to community and social programming, care coordination and specialists. PCP determines which team-based resources are needed.
Continuity of Care	Connections are relationship-based through known providers with follow-up and follow-through PCP is kept in the loop through on-going communication and collaboration.
Patient and family-partnered care	Grassroots co-design informed by both patients and caregivers. Care is orchestrated by the family physician enabling patient access to a variety of services and includes patient feedback via surveys and active Patient Advisory Group
Measurement, continuous QI and research	Metrics reported every two weeks to ensure on-going improvement. PCPS and IP Team provide ongoing feedback to improve the TeamCare platform, communication and collaboration. On- going evaluation by University of Toronto, IHPME University of Toronto.

Pillars	Description
Training, education and continuous Professional Development	Models that attract learners and trainees

Appendix B: Current Sites "Advancing Access to Team-Based Care"

LHIN	Expanded Interprofessional Teams + Existing Services	Existing Services Only
ESC LHIN	Windsor Community Family Health Team and CMHA Windsor-Essex	
		Chatham-Kent CHCs
SW	London InterCommunity Health Centre	
		South East Grey CHC
WW	Centre for Excellence FHT	
	Langs Farm CHC	
HNHB	CSC Hamilton/Niagara	
Central	Vaughan CHC (2 teams)	
	Black Creek CHC (2 teams)	
Toronto Central		Access Alliance
		Anishnawbe Health Toronto
		Parkdale Queen West CHC
		Planned Parenthood
		The Four Villages CHC
		Centre Francophone de Toronto
		Vibrant Healthcare Alliance
		East End CHC

LHIN	Expanded Interprofessional Teams + Existing Services	Existing Services Only
		LAMP CHC
		Rexdale CHC
		Davenport Perth Neighbourhood CHC
		Flemingdon CHC
		Regent Park CHC
		South Riverdale CHC
		Stonegate CHC
		Michener Institute
		Village FHT
	Unison CHC (additional mental health)	
Central East	Carea CHC	
	Scarborough Centre for Healthy Communities	
South East	Kingston CHCs	
	Rideau Community Health Services	
Champlain	Seaway Valley	Sandy Hill CHC
		CSC de l'Estrie
North West	NorWest CHCs	

Appendix C: Frequently Asked Questions

How did you determine the 5000 primary care physicians?

A recent study identified that there were 8828 comprehensive primary care physicians in Ontario.30 Physicians who have access to interprofessional teams were subtracted from this number to determine the need (2200 physicians work with a FHT, 300 physicians with a CHC, 1500 physicians have access through existing TeamCare programs). This implies that the number of primary care physicians without access to teams is 4828 (approximately 54%). We then rounded up for simplicity and to ensure an over-estimate.

Are all existing TeamCare sites fully operational?

About ½ of the TeamCare sites have not received any additional staff and would require additional funding to fully support 100% of the primary care physicians in their region.

How does TeamCare work when teams are already at capacity?

Many existing organizations have attempted to use quality improvement to streamline and ensure continual access. Other types of activities are being utilized to ensure appropriate access such as group visits, e-consult/ videoconference, case management, etc). Within a quality improvement framework the goal will be to continually monitor wait times to ensure continued streamlined access. Ensuring that people who need the service most is also critical – this does not mean denying service however it might mean helping the person navigate to more appropriate services (if they have extended health insurance).

Will more funding be required?

While the intent is to build on existing resources, there will need to be significant investment of additional funds to realize the full vision. As we determine more precise needs for TeamCare, the intent is to determine the amount of investment required for full implementation.

Appendix D: List of Reviewers

Reviewers for V3:

Dr. Cathy Faulds

Walter Wodchis, PhD

Dr. Merrick Zwarenstein

Simone Dahrouge, PhD

Dr. Laura Muldoon

Dale McMurchy,

Windsor TeamCare: Mark Ferrari, Claudia den Boer

Reviewers for V4:

Alliance Research Advisory Council: Dr. Imaan Bayoumi, Kathryn Brohman, PhD, Robert Case, PhD, Simone Dahrouge, PhD, Liben Gebremikael, Axelle Janczur, Dale McMurchy, Dr. Laura Muldoon, Dr. Andrew Pinto, Dr. Merrick Zwarenstein

Dr. Cathy Faulds

Walter Wodchis, PhD

Moira Stewart, PhD, Professor Emeritus, Centre for Studies in Family Medicine, Western University

Dr Joshua Tepper, CEO, North York General

Dr. Gordon Schacter, London Middlesex Clinical Lead, South West Local Health Integration Network

Dr. Brian Klar, Chief of Family Medicine, William Osler Hospital

Dr. Mohamed Alarakhia, Digital Physician Lead for Waterloo Wellington Health System and Director, E-Health Centre of Excellence, The Centre for Family Medicine Family Health Team, Kitchener, Ontario

Primary Care Working Group of Premier's Council

All TeamCare projects