Focus on Value Based Health Care

Patient Health System Summit
October, 2019
Introduction to primary care & CHCs in Ontario

TeamCare

Social Prescribing

Patient Reported Outcomes
Primary Care in Ontario

• Mix of primary care models in Ontario
• Lack of equity in access to team-based care
  • ~70% do not have access to teams
• Team-based models include:
  • Aboriginal Health Access Centres
  • Community Health Centres
  • Family Health Teams
  • Nurse Practitioner Led Clinics
Value Based Health Care
Community Health Centres

• Community based & community governed
• Salary-based primary care model
• Interprofessional teams including health promotion & community development
• Integrated care & partnership building
• Performance metrics & outcomes (including accreditation)
Model of Health and Wellbeing
Health and Well-being

Stress from poverty 'over-medicalised'

Family doctors needed better access to alternatives to drug treatment. - Helen Stokes-Lampard, chair of the Royal College of GPs

Physicians estimate that 21 percent of medical care is unnecessary — a problem that costs the health care system at least $210 billion a year. KHN hosted a forum on how too much medicine can cause harm.
TeamCare is part of the solution

- Facilitated-outreach approach to connecting non-team primary care providers and their clients to IP teams at CHCs and FHTs
- Each region co-designs program with clients and providers
- Quadruple Aim Evaluation including:
  - Client experience and outcomes
  - Costing analysis
  - Provider experience
STRONG PRIMARY CARE THROUGH SEAMLESS ACCESS TO TEAMS
Preliminary Results

• By the numbers
  • Over 22,000 people have access to teams (and growing)
  • Close to 105,000 visits
  • 1625 physicians

• What people are saying
  • I have benefited greatly and it has changed my life
  • It felt very human – I am going to continue to access services
  • Improve quality of life for my patients
  • TeamCare is providing essential services
  • Cannot imagine my practice without teamcare
Social Prescribing

Individual with complex needs

Primary care clinician makes a social prescription - a referral - after fulsome discussions

Navigator links individual to appropriate resources, and supports their journey to wellbeing

Individual connected to social and community supports, with invitation to engage, contribute, and give back
Key Components: The role of primary care

“You look around at other hospitals - they don’t even ask you what you want. They tell you, you’ve got to do that, and this is it. They don’t give you any choice. Here, they ask. They involve you in any decision that is happening.”

– Client from Centretown CHC

“It’s an invitation as opposed to just a resource that’s available to everyone so I’m grateful for the personalization, it made us feel like WOW!”

– Client from Rexdale CHC

"Depending on the week, anywhere from 25% to 50% of the time my appointments are not medical in nature.”

- Primary care provider, South Georgian Bay CHC
Collaboration and co-creation

“After being laid off, I had lost my pride. By getting involved as a Health Champion, I was helping to fight my isolation while helping people in my community fight their loneliness. I am now proud of myself, knowing that I offer others the chance to follow this good ‘prescription’... that of putting life into our lives!”

– Health Champion,
CSC du Témiskaming
Measuring What Matters

- Health Equity
- Process measures & financial accountability
- Patient Reported Outcomes
- Patient Reported Experience
- Patient Involvement in Care
- Qualitative Data
Questions/Discussion