TEAM CARE – EAST LONDON

LONDON INTERCOMMUNITY HEALTH CENTRE – OCTOBER 2019

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Improving Health Together

BACKGROUND/DESCRIPTION

- PINOT (pilot project) launched at the Health Centre in 2016
- Funding announcement April 2018 to expand PINOT. Received funding fall of 2018.
- Target population: solo-practice physicians in East London and the most vulnerable people (lowest income bracket) in East London. Research on population data showed that both groups had the lowest access to team-based care in London.
- Received funding for systems navigation, social work, psychology, respiratory therapy, and footcare
  - Switched one social worker to a physiotherapy assistant with approval from the Ministry

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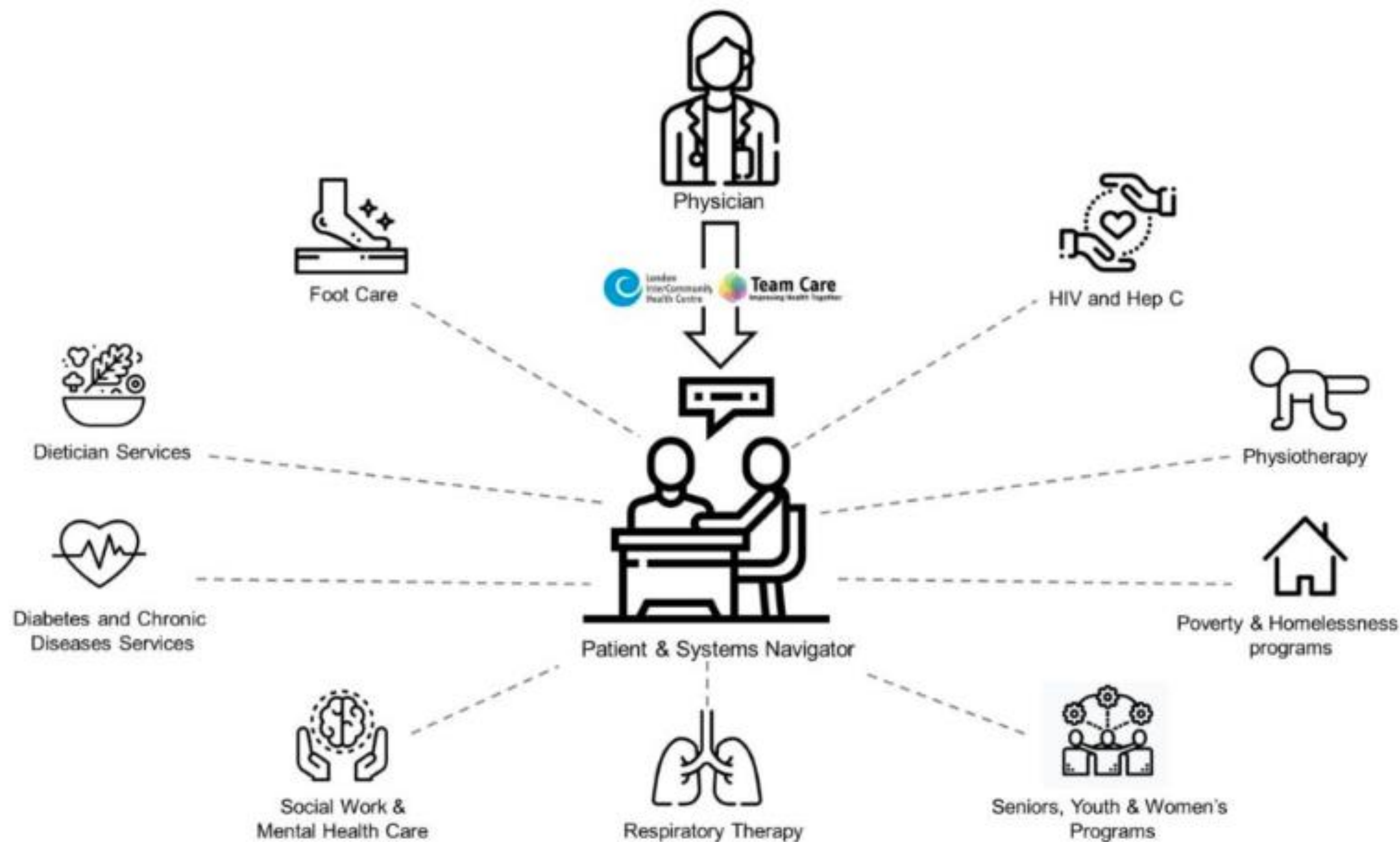
MODEL OF CARE



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PROGRAM DESIGN AND IMPLEMENTATION

ASSESSMENT

IMPLEMENTATION

SUSTAINABILITY

- First few months we interviewed existing clients and physicians who have participated in program to learn about their experience of what could go better (continuous improvement + quadruple aim at the core of assessment)
- Integrated team that expands to all interprofessional health care providers at the Health Centre with the exception of primary care. Once client is referred, they can access any of the Health Centre's programming
- Implemented a physician advisory committee, client advisory committee, and a systems advisory committee
  - Physician and client advisory committees work with a co-design framework

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PROGRAM DESIGN AND IMPLEMENTATION

- Two different ways to see Team Care health care providers:
  - Clients see providers at the Health Centre
  - Select providers at the physician site

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IMPLEMENTATION CHALLENGES

- Communication between physician and providers
- Physician engagement
- Referrals to services outside of mental health and physiotherapy
- Provider buy-in
  - Perception that Team Care clients are different than Health Centre clients

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IMPLEMENTATION AND PROGRAM SUCCESS

Integration

Registration

Systems Buy-in

New Space

40 Physicians
300+ clients
1200 encounters

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SUSTAINABILITY

- Advisory Committees and Continuous Improvement
  - Provider Buy-in
- Team Care – Phase II with Thames Valley Family Health Team
- Team Care/SCOPE and Ontario Health Teams

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KEY LEARNINGS

- Relationships and academic detailing are important for physician engagement
- Education and Communication
- Integration – seeing Team Care as a model of care not a separate program
- Continuous improvement and quadruple aim at the core of the model and the success of the program
- Ensure there is engagement at multiple levels:
  - Systems | Leadership | Physicians | Providers | Clients

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