

Advancing Access to Team-Based Care

Executive Leadership Network Meeting – Oct. 29, 2019

Jennifer Rayner
Walter Wodchis
Elana Commisso
Jennifer Im



Alliance for Healthier Communities
Alliance pour des communautés en santé

Agenda

1. Introductions
2. Research Team Presentation
3. Participating Sites' Presentation
4. Open Discussion / Q + A

Overview

1. Provincial and Regional Context
2. Overview of TeamCare
3. AATBC Research & Evaluation Framework
4. Preliminary Results
5. Early Lessons
6. Next Steps

Provincial Context



Existing Sites (SPiN,
PCO, PINOT, etc)



New
Implementation
sites with facilitator
(4 LHINs currently)



Interprofessional
Team Proposals
(expansion of
team-based care)
17/18, 18/19)

Advancing Access to Team-Based Care

Local Design & Adaptation

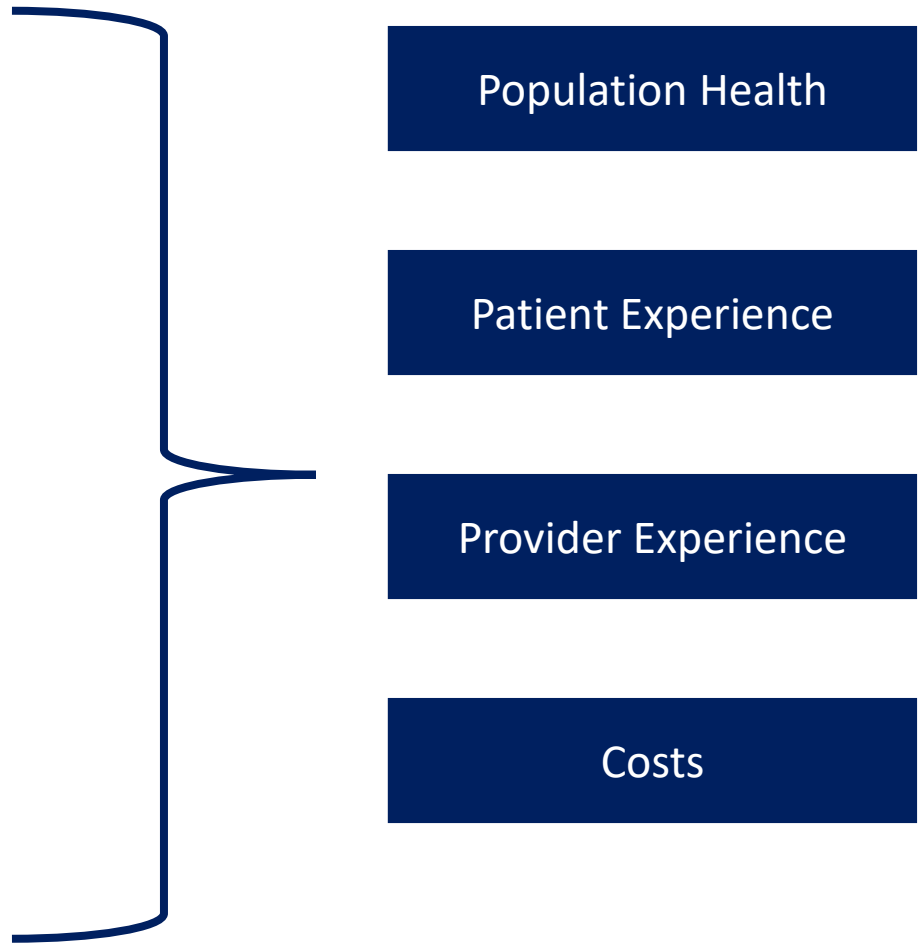
- Engage local stakeholders and end-users, including clients and providers, in defining, and planning for, change
- Build on, and enhance, existing local competencies and capacity to support ongoing collaboration, integration and improvement
- Co-design and test new operational practices and procedures that support meaningful collaboration
- Use data to inform locally-defined change and improvement goals
- Support alignment with existing initiatives at regional and sub-regional levels
- Foster the development of local change champions, and communities of practice to support continued learning, communication and partnerships

Facilitation



- Supporting change and bridging cultures
 - Facilitation helps build cross-boundary teams & communities of practice
 - Facilitation creates greater integration by bridging organizational cultures not changing them

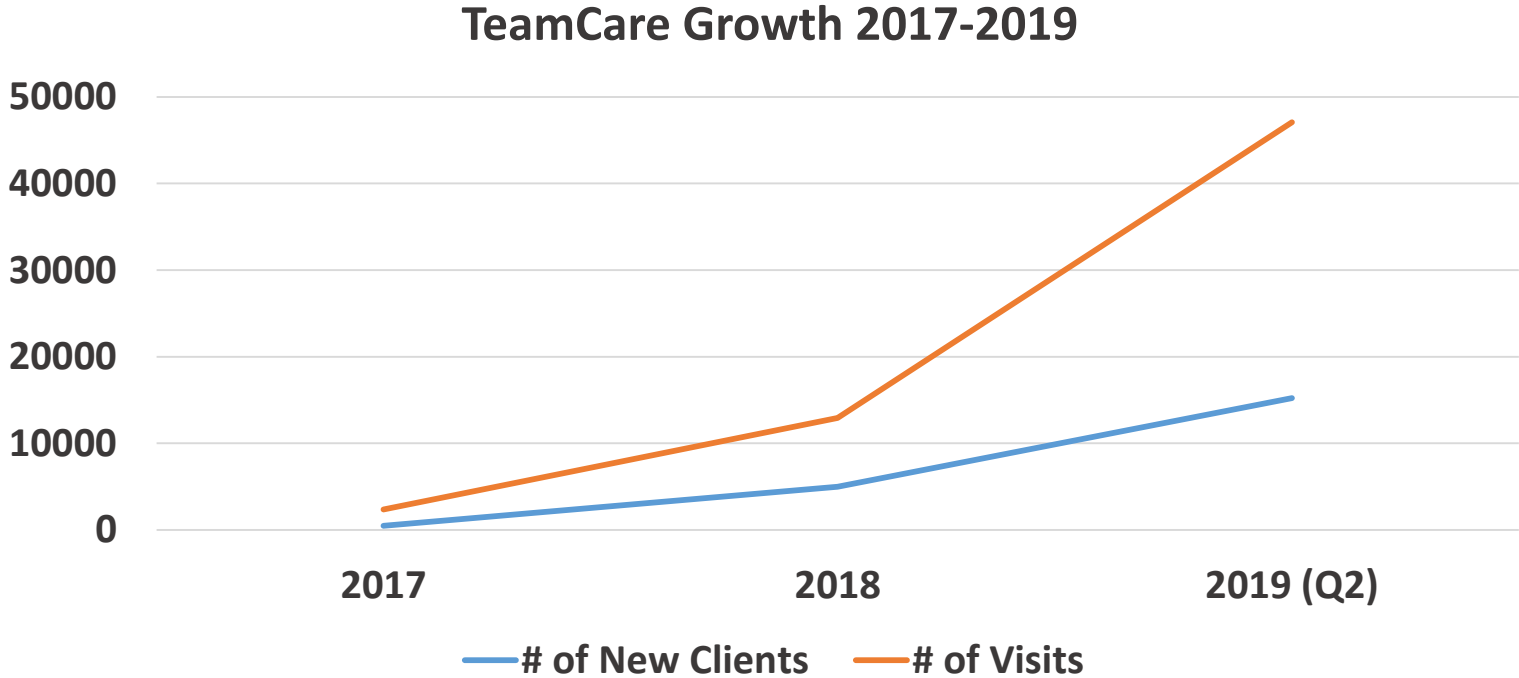
TeamCare Process



Access to Team-Based Care (w/o PCO)

	2017	2018	2019	Total
# of participating sites	8	20	27	27
Total # of new clients	465	5,004	15,240	20,709
Total # of visits	2,358	12,935	47,059	62,352
# of participating PCPs and NPs	-	-	-	1,153

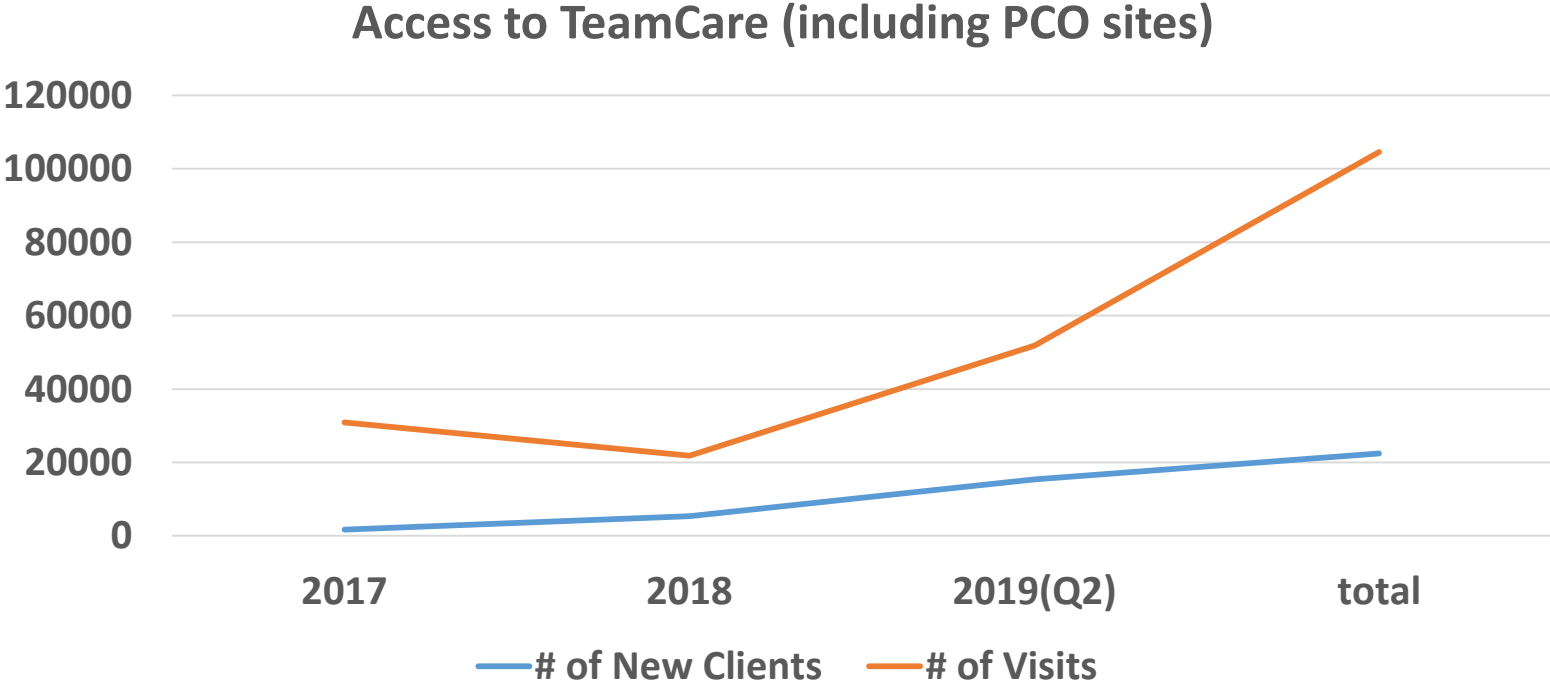
Access to Team Care



Access to Team-Based Care (w/ PCO)

	2017	2018	2019	Total
# of participating sites	13	24	29	29
Total # of new clients	1,713	5,315	15,371	20,709
Total # of visits	30,937	21,843	51,819	104,590
# of participating PCPs and NPs	-	-	-	1,323

Access to Team Care



Research & Evaluation



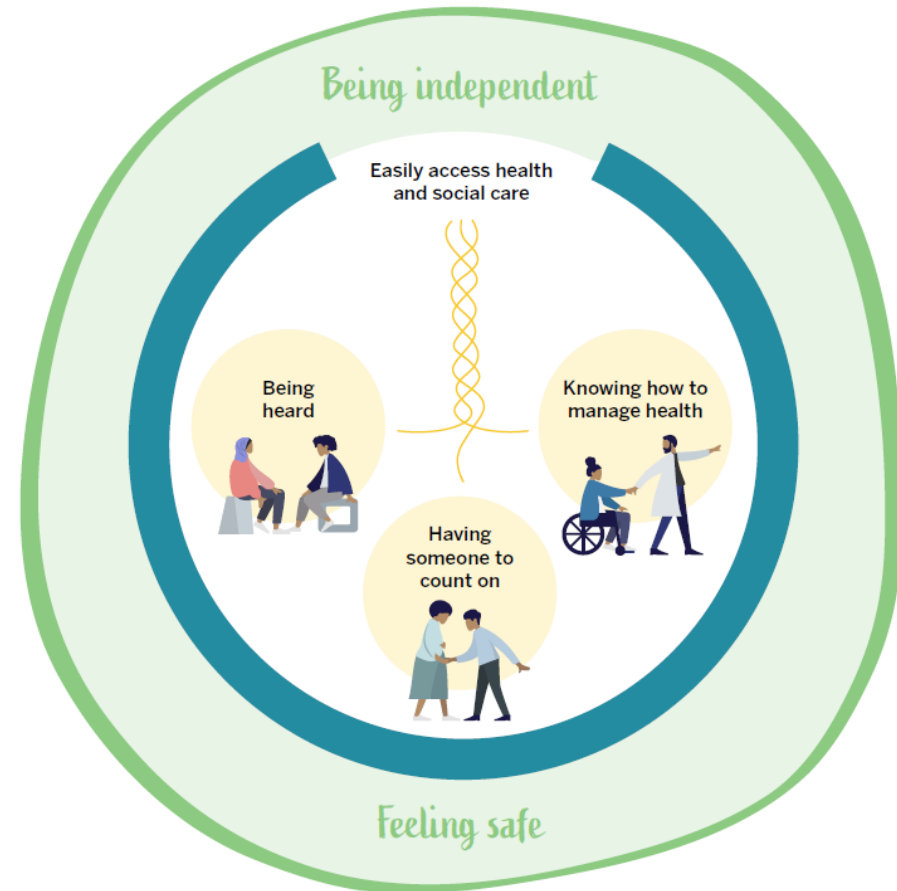
AATBC Research & Evaluation Program

- **Purpose:** to evaluate new locally-designed models of care collaboration/team-based care in diverse regional and sub-regional contexts across Ontario
- **Local context matters:**
 - Each model is adapted to its context, capabilities of sites, primary care collaborators, and patient needs
- **Early results:**
 - Provider Readiness, Team Climate
 - Patient Experience

Research and Evaluation Context

The six competencies for doing integrated care well are...

- 1/ Framing and reframing issues to create clarity, enable shared purpose and build consensus.**
- 2/ Taking the perspective of others to build trust and create safe spaces for collaboration.**
- 3/ Co-designing care with patients and caregivers to ensure systems provide care that meets patients' needs.**
- 4/ Systems thinking to optimize the performance of the system as a whole**
- 5/ Sharing power to enable others to make decisions and act**
- 6/ Reflective learning that enables learning from successes and failures.**



Quadruple Aim Framework

1) Patient Experience



Access to Care
Coordination
Communication
Continuity
Quality of Life
SDOH

2) Provider Experience



Team Climate
Knowledge Management
Leadership
Motivation
Relational Coordination
Normalization

3) Population Health



Primary & specialist
care
ED Use
Hospitalizations
Post-Acute Care

4) Cost of Care



TeamCare Service
Utilization
Primary Care and
specialist visits
ED visits
Inpatient hospitalizations
Post-Acute Care
Total cost of care

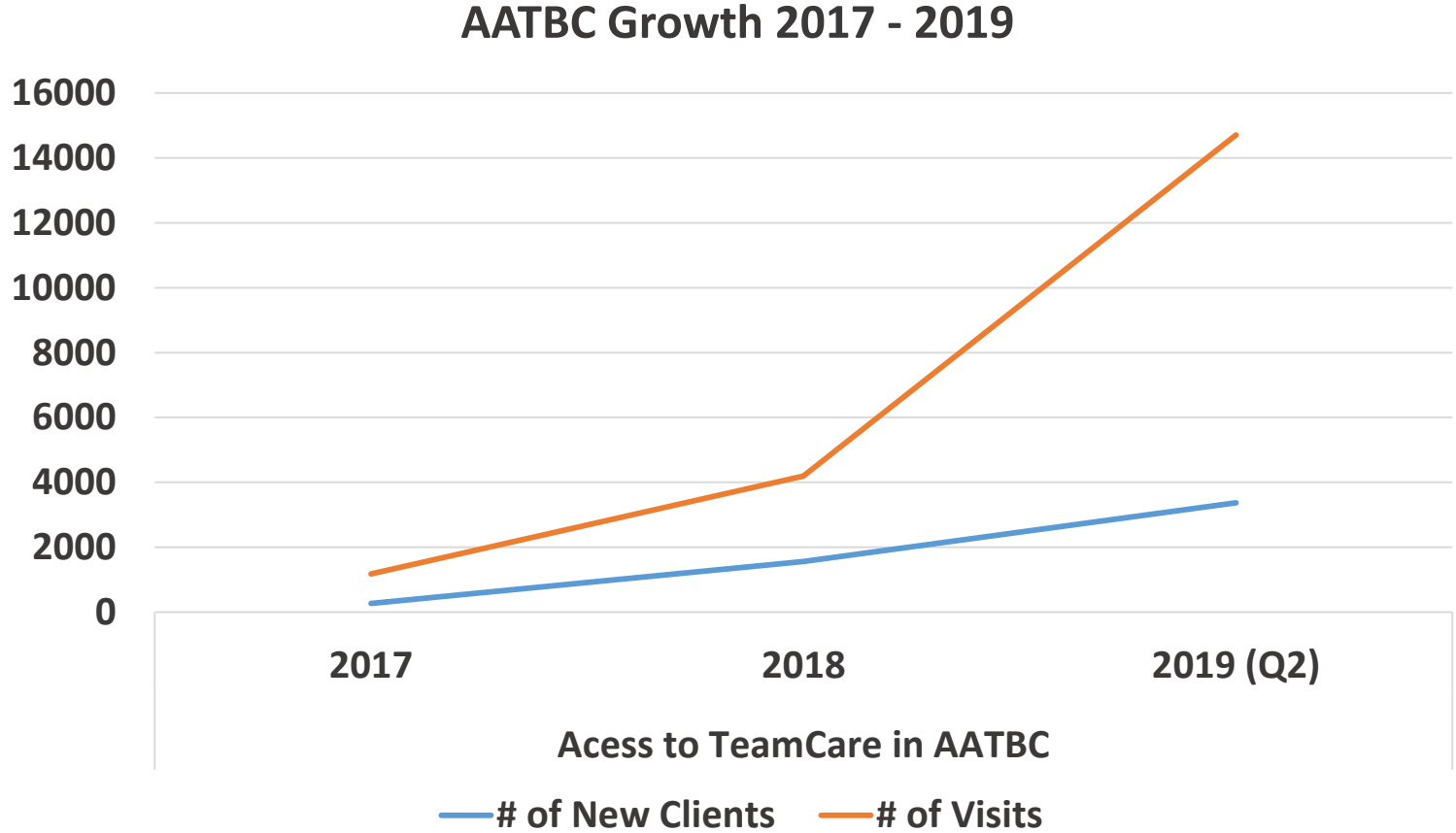
Preliminary Results



Advancing Access to Team-Based Care

	2017	2018	2019	Total
# of participating sites	1	4	5	5
Total # of new clients	265	1560	3374	5199
Total # of visits	1178	4189	14709	20076
# of participating PCPs and NPs	-	-	-	464

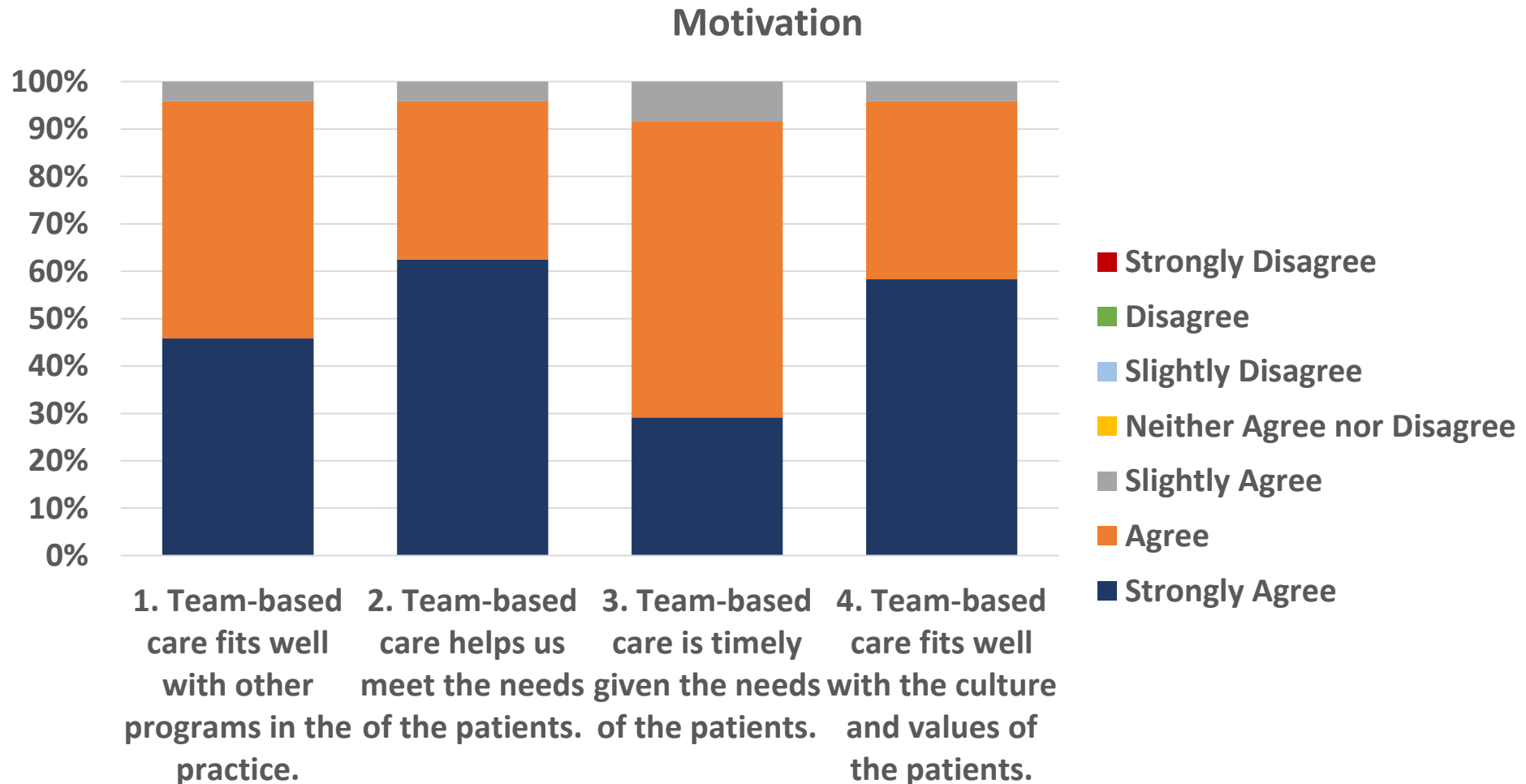
Advancing Access to Team-Based Care



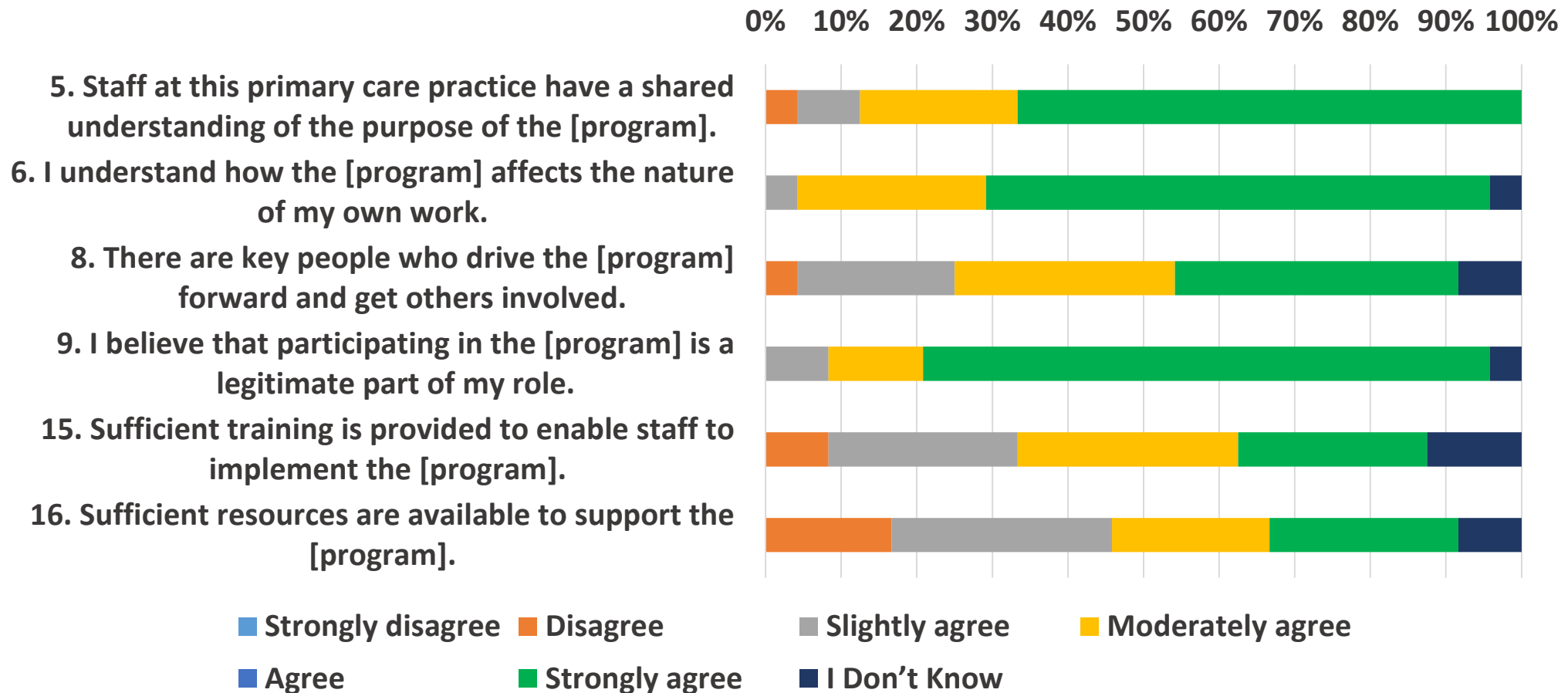
Overview of Findings

Type of Data	Number of Participants
Patient Experience	
• Surveys	2 sites; n = 38
• Interviews	1 site; n = 6
IP Team Provider Experience	
• Baseline Surveys	5 sites; n = 74
• Follow-up Surveys	2 sites; n = 22
• Focus groups / interviews	5 sites; n = 77
Primary Care Provider Experience	
• Baseline surveys	3 sites; n = 24

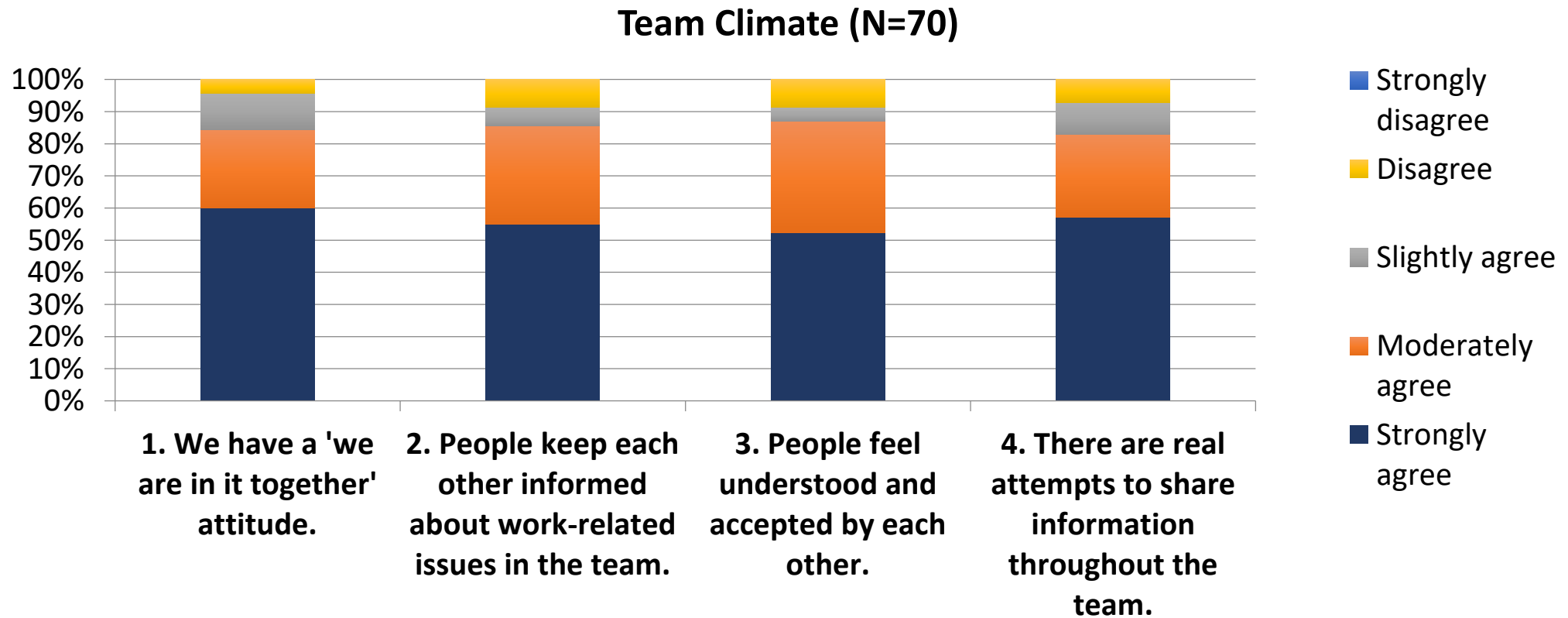
Primary Care Provider Motivation to Participate



Normalization of Team-Based Care for PCPs

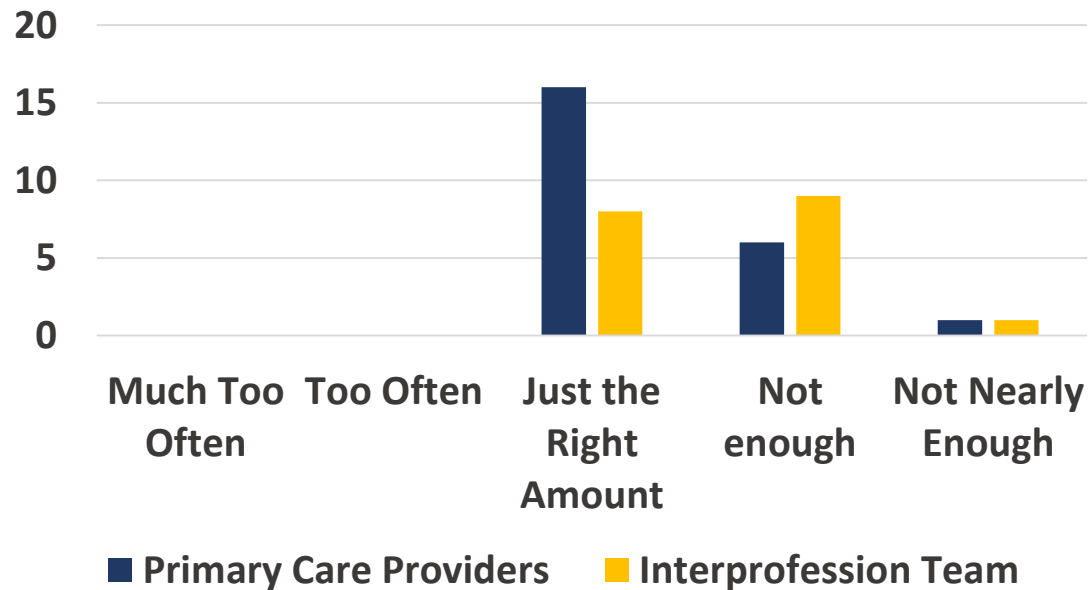


Interprofessional Team Readiness

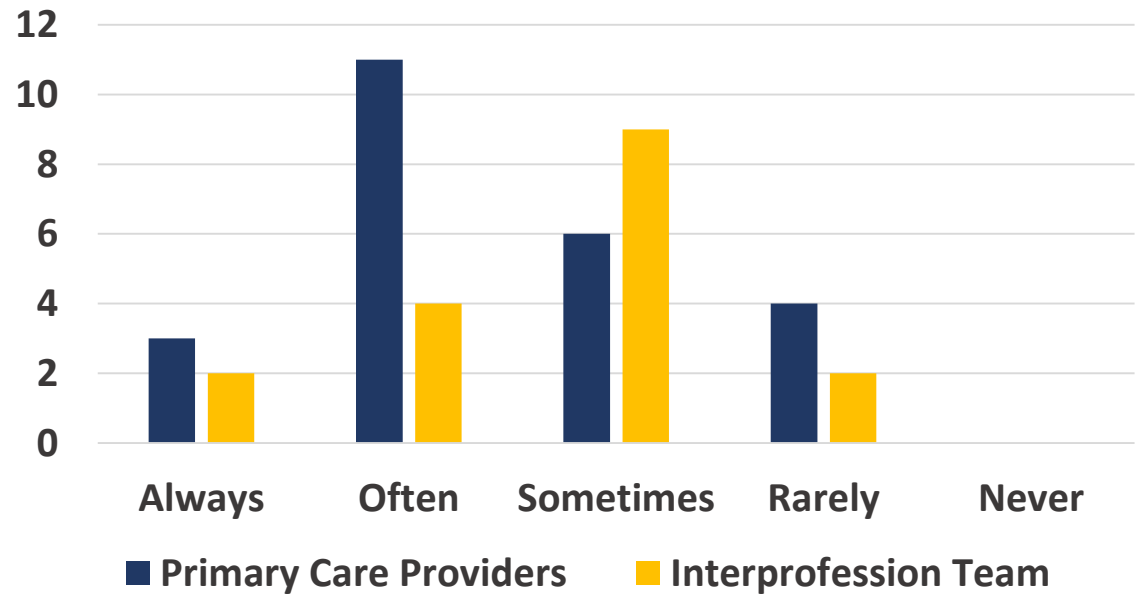


Communication

Q: How frequently do [IP team members / PCPs) communicate with you about patients in team-care?

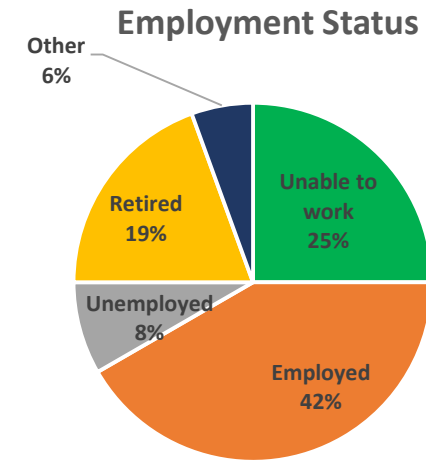
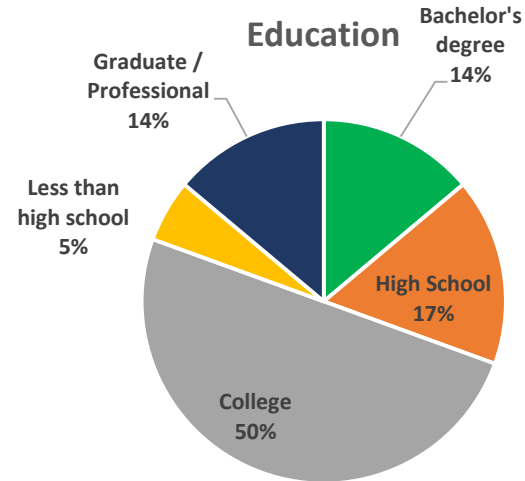


Q: Do [IP team members / PCPs] communicate with you in a timely way about patients in the [program]?

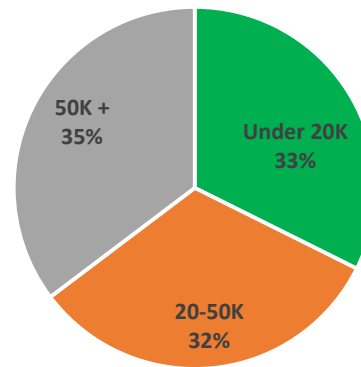


Patient Demographics

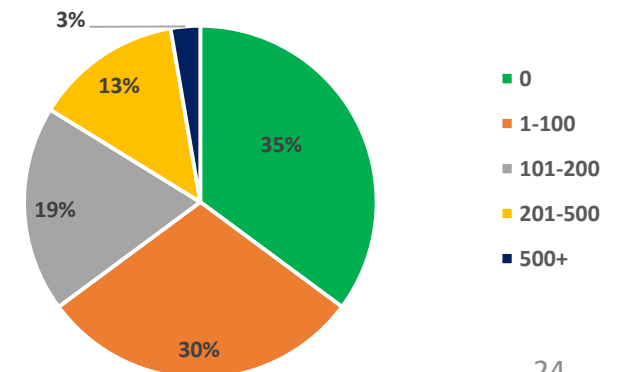
Patients	n=38
Age	
• Under 25	5
• 45-64	1
• 25-45	8
• 65 and over	7
• Did not answer	3
Sex	
• Female	14
• Male	21
• Did not answer	3



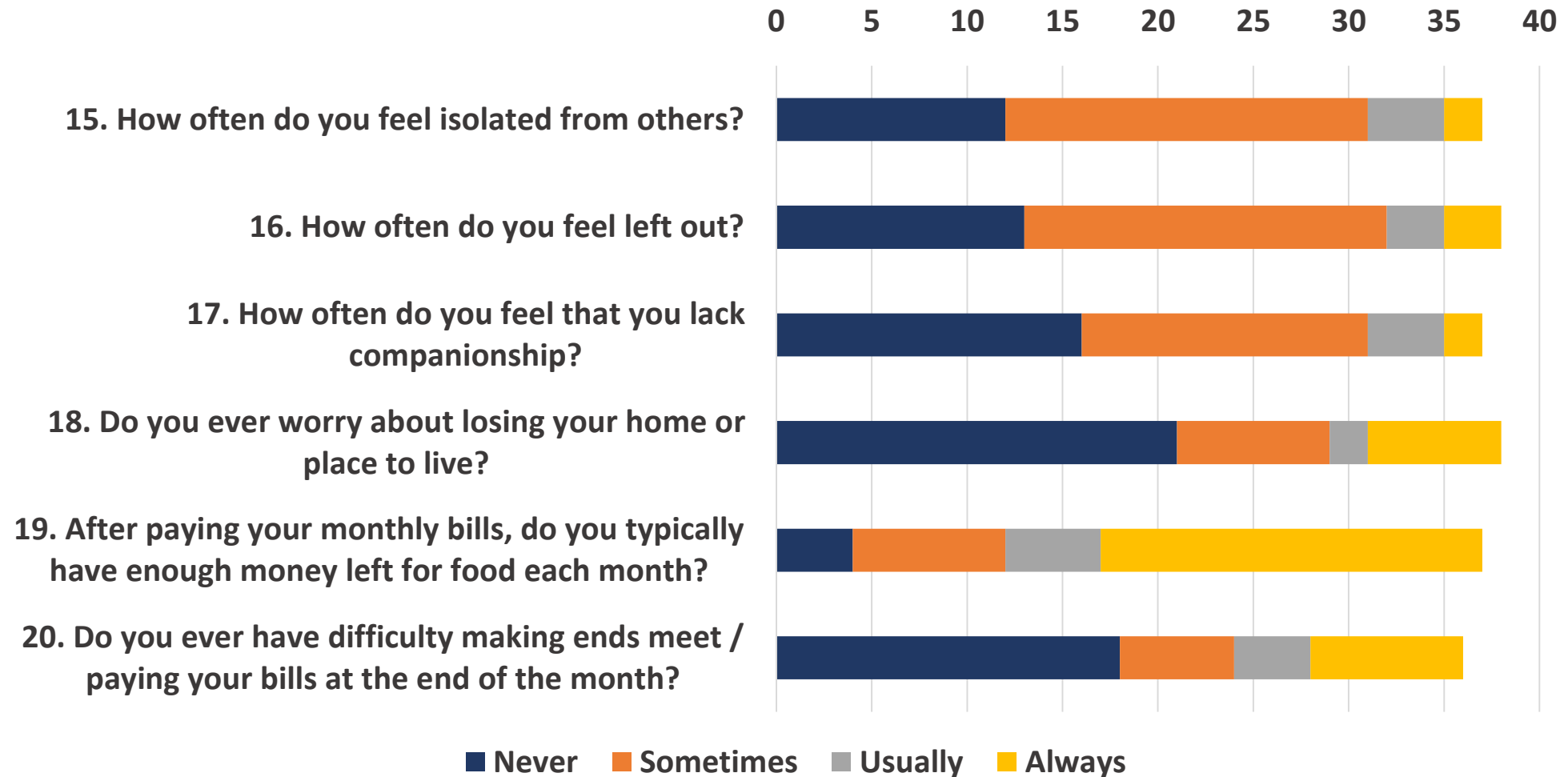
Annual Household Income



Out-of-pocket spending on care in the past 3 months

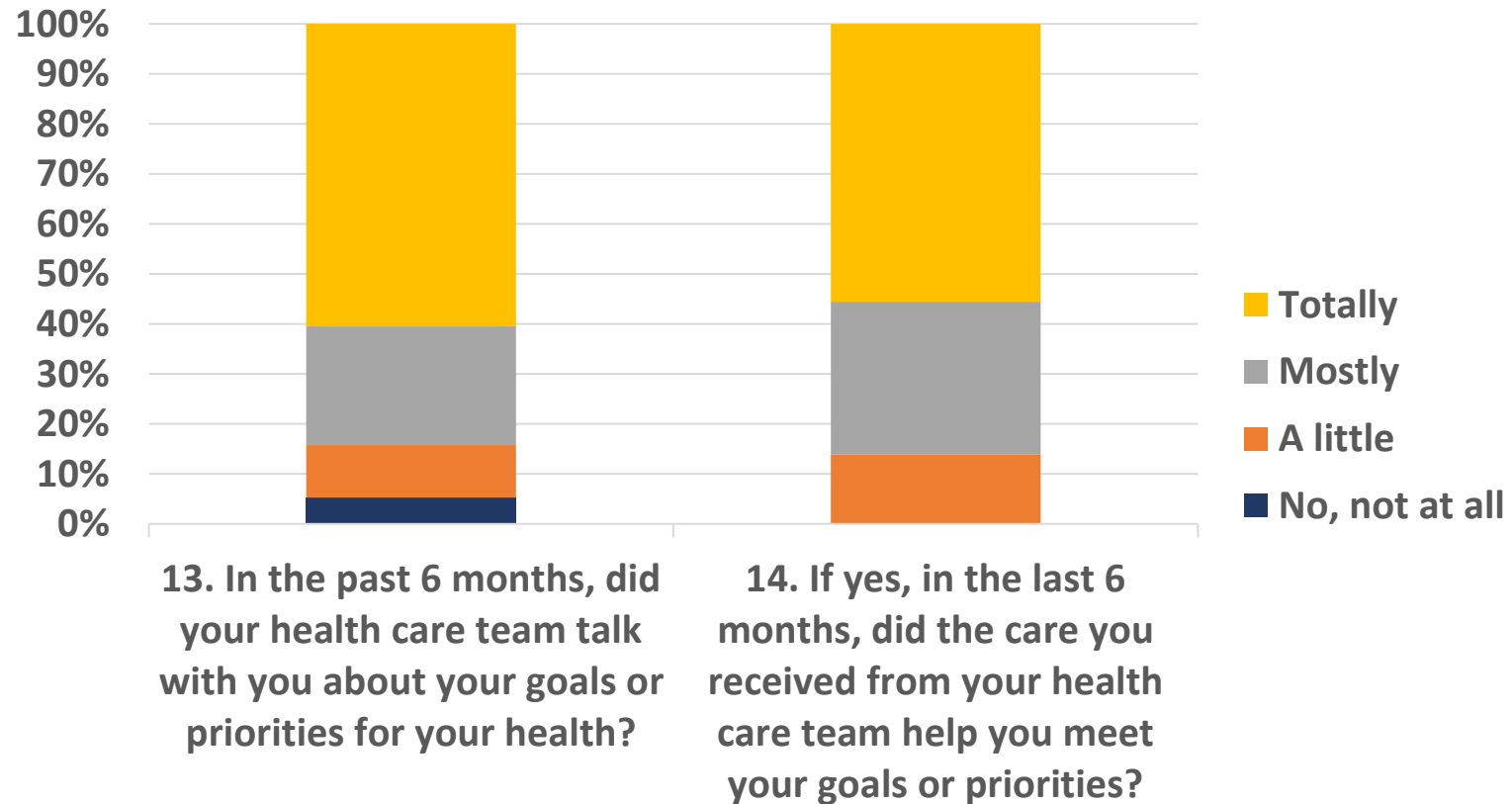


Patient Demographics - SDoH



Being Heard

Meeting Client's Goals and Priorities (n=38)



Focus Group Findings



Team-Based Care: Wins

*“...a phrase that [leader] uses all the time is culture by design...a big piece of that is **who you're bringing in to be a part of your organization**, making sure they share those values and beliefs...the organization tries to provide a lot of **opportunity for growth** and when I say that I mean by like challenging peoples' internalized beliefs already. Like at our all-staff days we'll have presentations on trauma-informed care or [IP team provider] will give some talks about how do you as a caregiver or somebody in the caring profession care for yourself. So there's a lot of – **there's a drive here for continual betterment.**”*

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of stuff.”*

Team-Based Care: Wins

“...a phrase that [d
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there's

“...a lot of **freedom to try it on your own**. Like “You think this might work, this might be helpful? Go try it. Okay, what do you need from us?” That’s something you hear all the time is “You like that idea? **How can I support you in making that happen?** Try it and then we’ll touch base and see how it’s going.” So there’s **a lot of openness** around that kind of stuff.”

Team-Based Care: Wins

“...a phrase that
piece of that is wh
making sure they s
provide a lot of op
like challenging
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worker] will g
somebody in the
there's

“...we're always working towards the **best client-centered care**, so no matter what debate or conversation we're having it always comes back to how do we – is this the best choice for the client, for the patient coming in and **no matter what's going on**. We try to adapt our situation to fit what they need.”

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Team-Based Care: Wins

“I feel definitely I’m not being rushed ... [IP team provider] made me feel very comfortable ... That’s half the battle with health care, I think.”

there’s

... now I could get a grip on anxiety and depression, it just made me stronger”

client-

... years, ... me with ... before I ... got a grip

... think ... that do ... me is ... that ... it’s ... stuff.”

Team-Based Care: Wins

“Well, I told [primary care physician] for about a year and half, two years, that I have extreme anxiety ... I have a hard time with people listening to my needs ... my life was hell before I started seeing [IP team provider member], and then once I got a grip on how I could get a grip on anxiety and depression, it just made me stronger”

Team-Based Care: Challenges

*“I do know from experience that if you're just sending a letter **it's hard to put a face to the recommendation** and then it is harder to build trust over time and even just trying to call the provider, that can be challenging as well.”*

“So if primary doctor providers, if they know what we're doing, which they don't, [and] we explain it to them, [and] we explain they believe and more and more for how long.”

“Communication especially...it's a little bit siloed”

Team-Based Care: Challenges

"Perhaps confusion...it wasn't explained properly. Honestly, 5-6 months after we had [program], I still don't know what am I doing..."

"...where did [the program] come from? Did you create it?"

Team-Based Care: Challenges

“Perhaps
Honestly,
don’t know

“...where
create it?”

*“... If I went to one of the managers and said **what communication are you having your staff send to the primary care providers** who have made these referrals **they wouldn’t know**...It’s just very unclear because it’s a separate program...**The person who’s managing this program is not managing any personnel** and then the people who are not managing this program are managing the personnel. **So the information is just not being disseminated about what is expected** – like about communication especially...it’s a little bit siloed”*

Team-Based Care: Challenges

“So a lot of times, I have clients that would walk in with a paper not knowing why they are here”

*“Perhaps
Hon*

*“I think
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*the full range of services or the potential of
those services.”*

...especially...it's a little bit siloed”

Team-Based Care: Challenges

*“I think the onus is on us ... to make those connections ... **Physicians don’t understand ... the full range of services or the potential of those services.**”*

Early Learnings

Truisms	Enablers
Leadership that enables change	<ul style="list-style-type: none">• Clear vision and direction for change• Dedicated time and resources for change work• Removal of obstacles
Strong organizational culture	<ul style="list-style-type: none">• Psychological safety• Growth-mindset
Effective teaming including with primary care (e.g. role clarity, communication)	<ul style="list-style-type: none">• Relationship building including learning about expertise, experience, and backgrounds

Practical Strategies

Enablers	Frontline examples
Clear vision protected time and resources	<ul style="list-style-type: none">• Visioning and collaborative goal-setting exercises• Role scoping• Empowering staff to problem-solve and test new ideas
Safe environment Growth-mindset	<ul style="list-style-type: none">• Creating feedback loops for open communication• Asking questions rather than making statements
Role clarity Clear communication pathways	<ul style="list-style-type: none">• Creating opportunities to connect PCPs and IP members (e.g. speed dating to learn about roles with PCPs)• Clear process maps

Next Steps

1) Patient Experience



Access to Care
Coordination
Communication
Continuity
Quality of Life
SDOH

2) Provider Experience



Team Climate
Knowledge Management
Leadership
Motivation
Relational Coordination
Normalization

3) Population Health



Primary & specialist care
ED Use
Hospitalizations
Post-Acute Care

4) Cost of Care



TeamCare Service Utilization
Primary Care and specialist visits
ED visits
Inpatient hospitalizations
Post-Acute Care
Total cost of care

Questions & Discussion



jennifer.rayner@allianceon.org

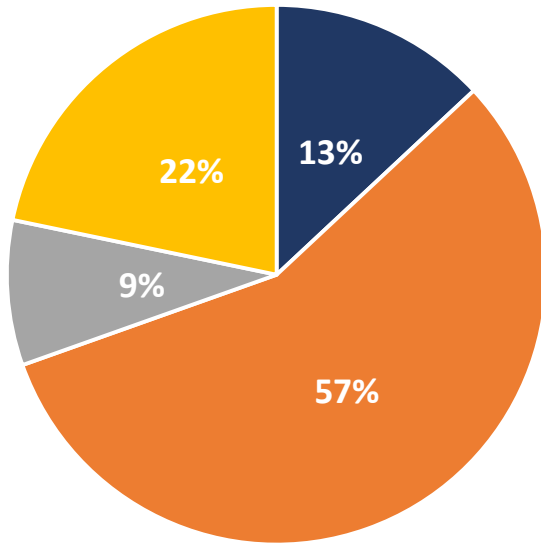
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Supplementary Slides



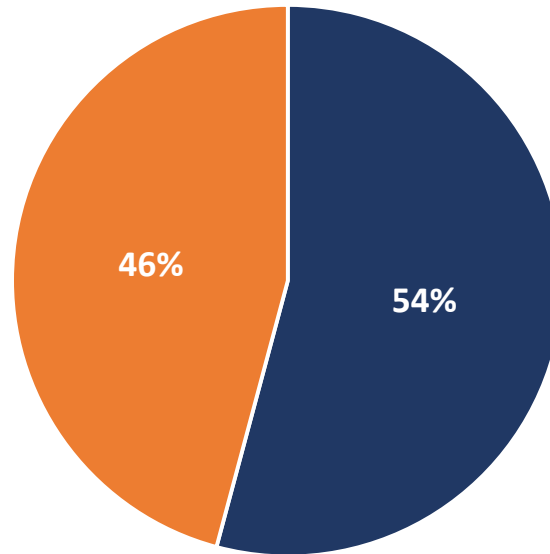
Primary Care Provider: Demographics

Age



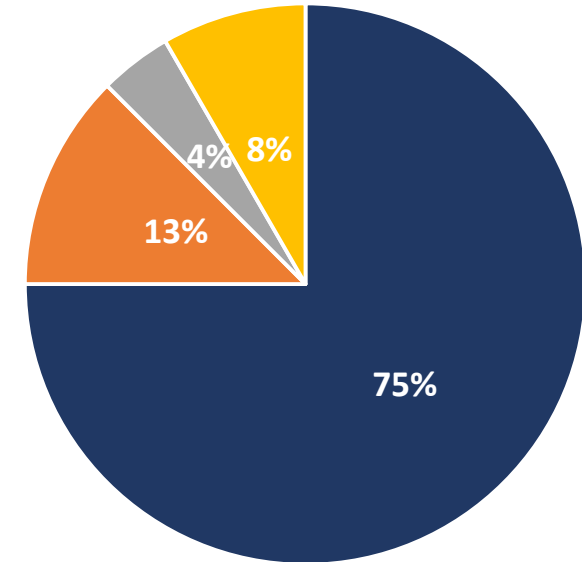
■ 20 - 30 ■ 31 - 45 ■ 46 - 60 ■ 61+

Gender



■ Woman ■ Man

Practice Model

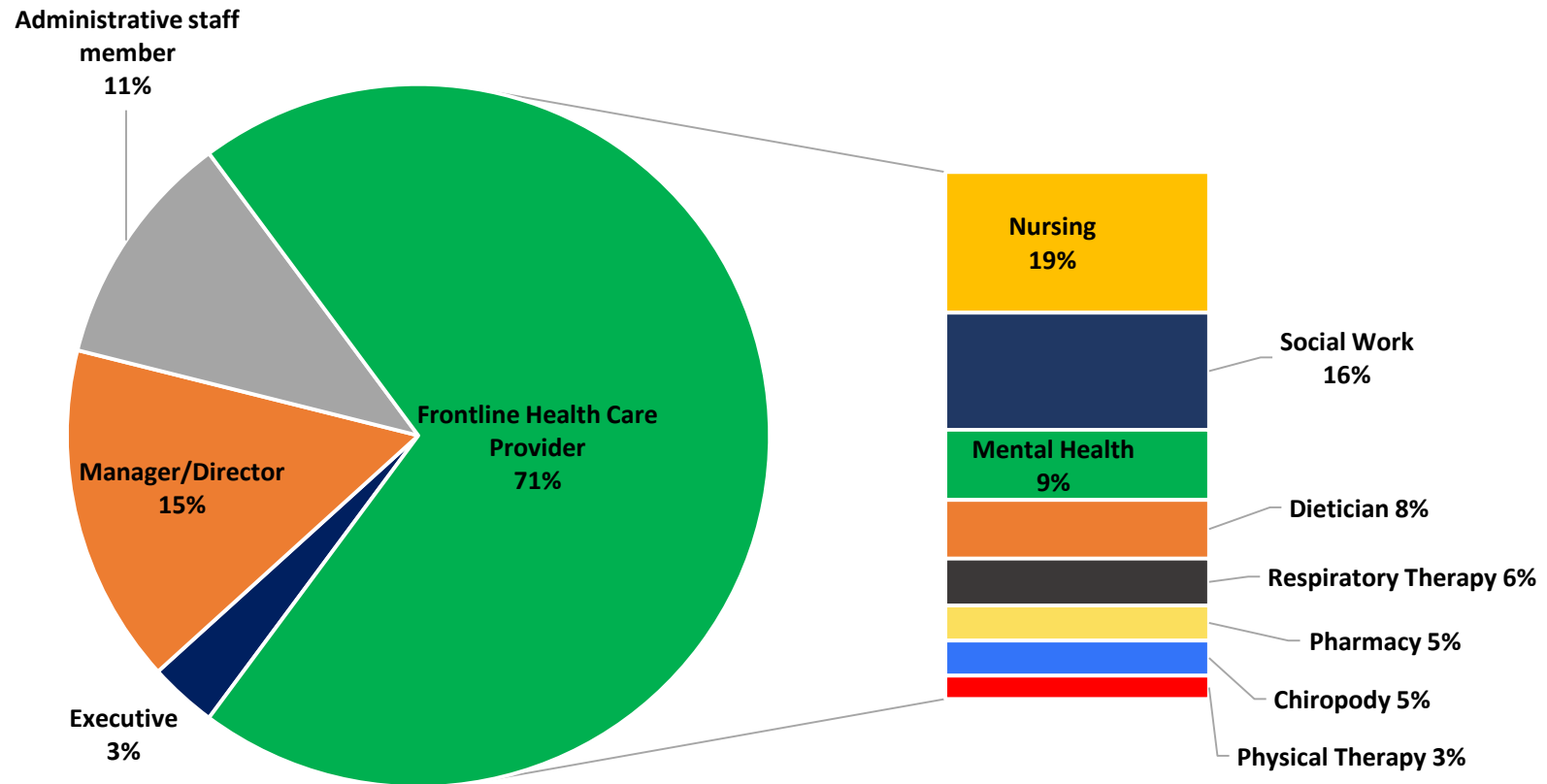


■ Family Health Organization ■ Family Health Group
■ Fee-For-Service ■ Family Health Team

IP Team Members

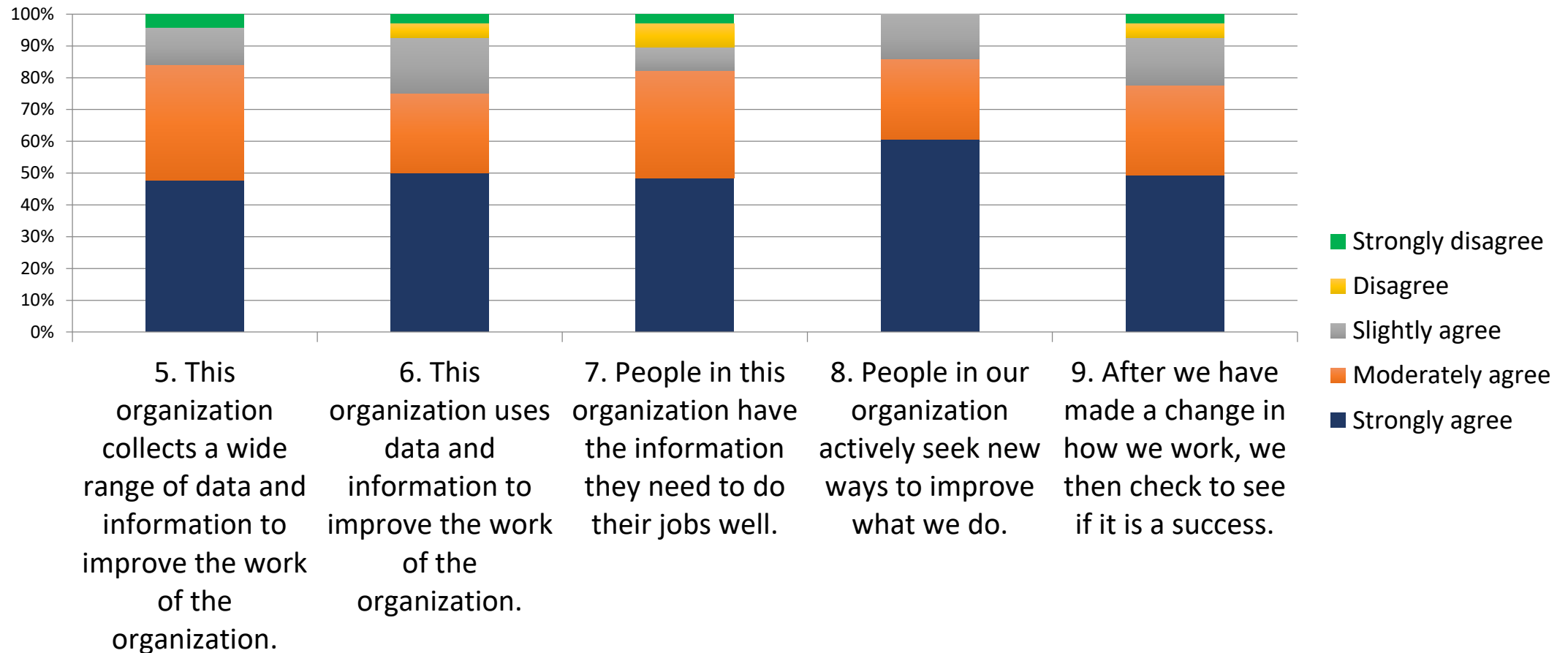
IP Team	n = 74
Age	
• 20-30	11
• 31-45	39
• 46-60	19
• 60 +	3
• Did not answer	2
Gender Identity	
• Woman	58
• Man	13
• Did not answer	3

IP Team – Primary Roles

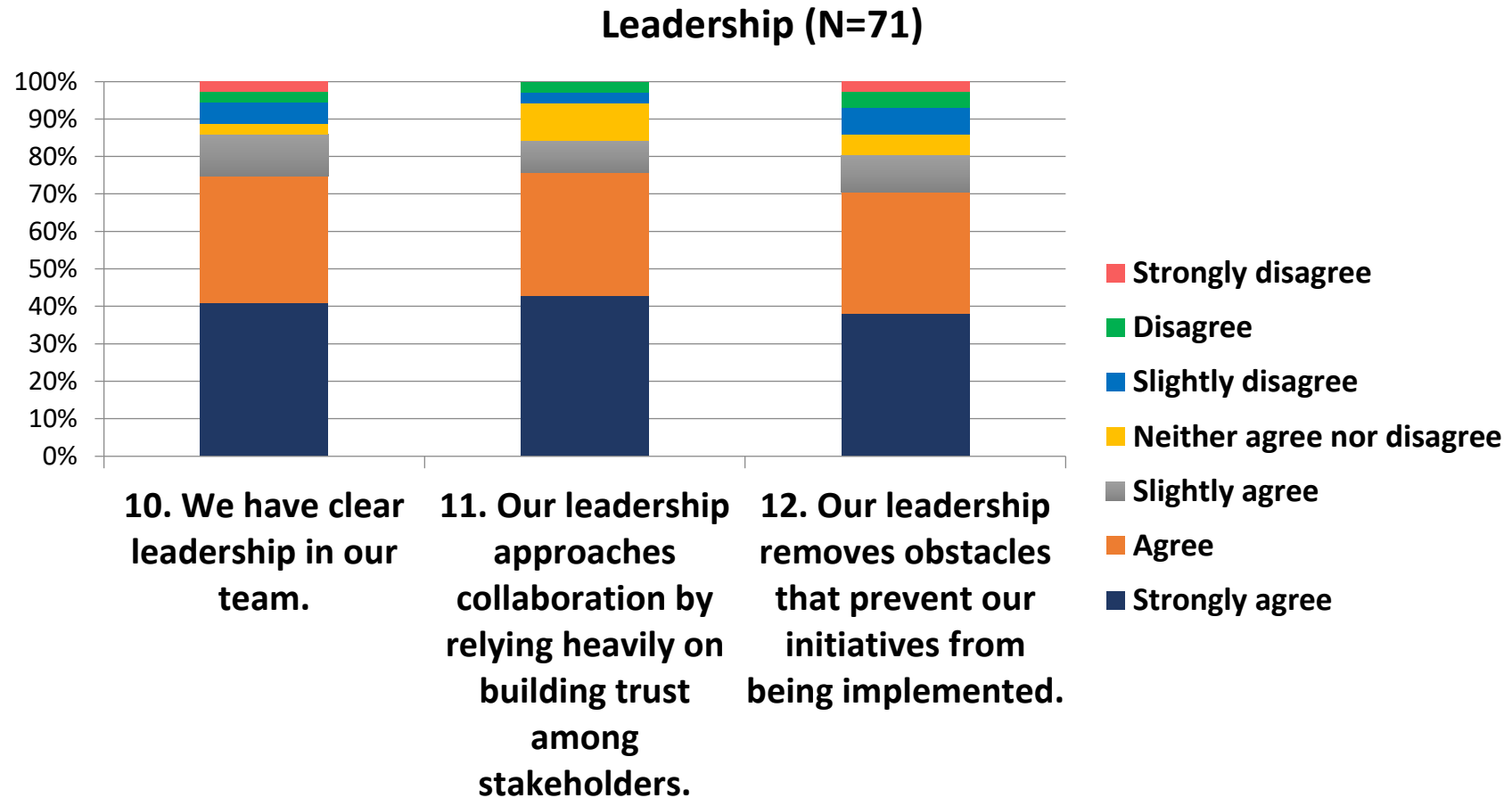


Interprofessional Team Readiness

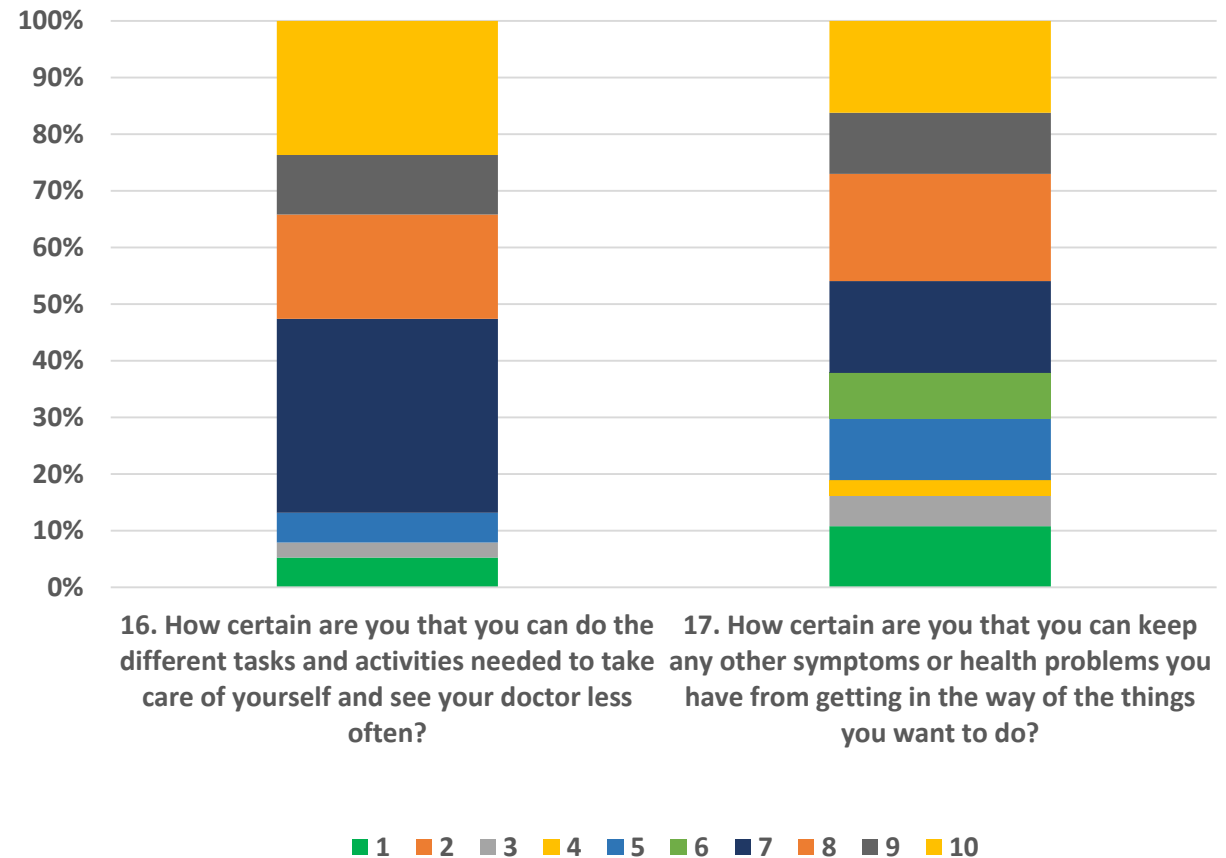
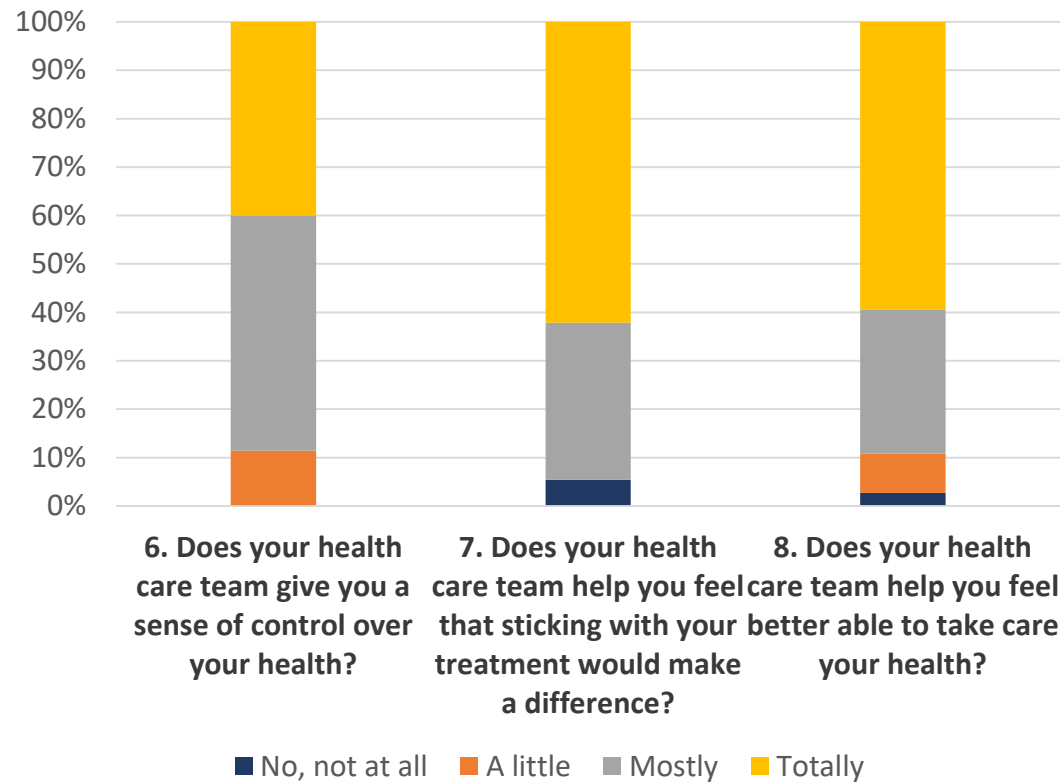
Knowledge Management (N=71)



Interprofessional Team Readiness



Knowing How to Manage Health



1 = Not certain at all - 10 = Totally certain