Integrated Primary Care Teams (IPCT)

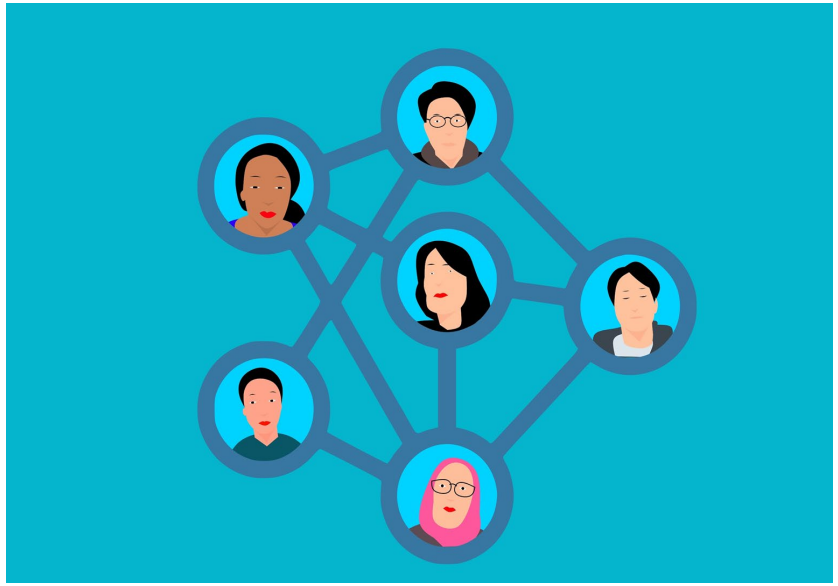
Guelph Wellington Ontario Health Team

What is an IPCT?

An Integrated Primary Care Team offers:

Coordinated seamless care across the health & social system

where the patient needs them, when they need them.



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GW OHT Integrated Primary Care Teams (IPCTs)

The GW OHT IPCT model builds on this strong foundation to fully realize both primary health care and population health management – both of which are required to support Ontario's COVID recovery and health system transformation

IPCTs are the first point of contact between a patient and the health care system and includes illness prevention, health promotion, diagnosis, treatment, and rehabilitation and counselling. **(Primary Care)**

IPCTs integrate health care services with services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment. Primary care is the element within primary health care that focusses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury. **(Primary Health Care)**

IPCTs improve clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models. Patient-level and population health data collected and used to identify where resources need to be adjusted to ensure equitable health outcomes for residents. **(Population Health Management)**

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What are the **benefits** to healthcare providers?

- Real-time information & communication from providers within the circle of care
- Development of trusting relationships with providers on the care team (including health and social services providers)
- Bringing services in the care circle vs. referring thereby eliminating many transitions of care
- Opportunity to shape what coordinated service delivery looks like

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What are the Benefits to Patients?

- Fewer providers with whom they have a relationship and who know their “story”
- Patients experience simplified, comprehensive care from “their team”
- Fewer duplicate processes and assessments
- More complex patients will have a “go-to person” on their team who will help manage and coordinate their care
- IPCT patients will be better informed and more capable of self managing their health needs

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Jane's Care Team - Current

MH&A

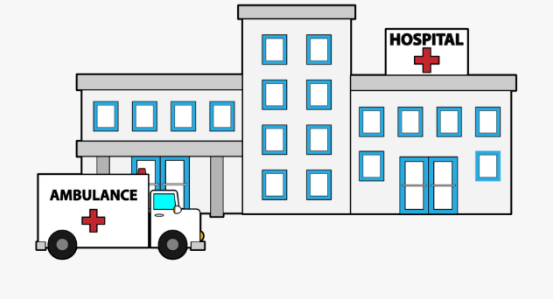
(Charting: Caseworks, other EMRs)

Housing
(Charting: Hifis)

Primary Care Team

(Charting:Telus)

Care Coordinator
(Charting: CHRIS)



Acute Care Team

(Charting: Meditech)

In-home Nurse
(Charting: Separate system)

In-home PSW
(Charting: Separate system)

Palliative Care

(Charting: Paper, Telus, other EMRs)

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Jane's Integrated Primary Care Team (IPCT)

Comprehensive primary care incl. palliative care and MH&A, care coordination, in-home service delivery, acute care, housing, etc.

(Integrated Documentation, Harmonized Privacy Policies & Practices)

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When Primary Care Teams sign up to be an IPCT……

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……They commit to the vision of an IPCT including:

1. Integrated functions of care coordination
2. Integrated in-home services (nursing, PSW etc.)
3. Other integrated services (e.g. MH&A, SGS, CADs etc.)
4. Implement “Go-To-Person” functions/role
5. Integrated privacy & security resources and standards
6. Sharing care plans between providers in the circle of care (Sharon Bot)
7. Common / shared digital health platforms (e.g. HyperCare, eReferral etc.)
8. Contribution of EMR data to support identification of IPCT patient complexity and population health approach to planning and resource allocation (Cody Bot, IDS)

First steps in becoming an IPCT site

- Identify a Change Management Lead
- Engage staff and physicians in the IPCT vision and model
- Co-design an implementation plan with staff and physicians
- Where do you want to start? Based on the experience of other IPCTs and system opportunities, in what order/at what pace is best to implement components of IPCT model (as listed on previous slide)

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IPCT Pilot Site Evaluation

- In Nov & Dec 2021, 22 participants from the 3 pilots sites participated in sessions to share their experiences with the IPCT model/pilots.
- They reported changes resulting from the IPCT model include improved communication, built relationships, increased efficiency & knowledge translation
- Patients who experienced the IPCT model were also consulted and reported positive experiences including smooth transitions

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IPCT Pilot Site Evaluation (cont'd)

Identified Challenges/Opportunities for IPCT Model Improvement

- CC finding it difficult to balance IPCT caseload with other cases
- Cross-border communication (patients receiving care/live in another region)
- CCP creation needed
- Centralized point person for all agreements E.g. privacy, data, MOU
- 2 people in same household who have different physicians & different CC's/2 different IPCT's

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IPCT Pilot Site Evaluation (cont'd)

Suggested Next Steps

Realize shared care plan via integrated documentation platforms and Sharon Bot

Patients do not know who has been in the home – *Gathering this is time consuming!*
Need to reduce this work

Integrate MH&A services, community services (e.g., Meals On Wheels) into IPCT

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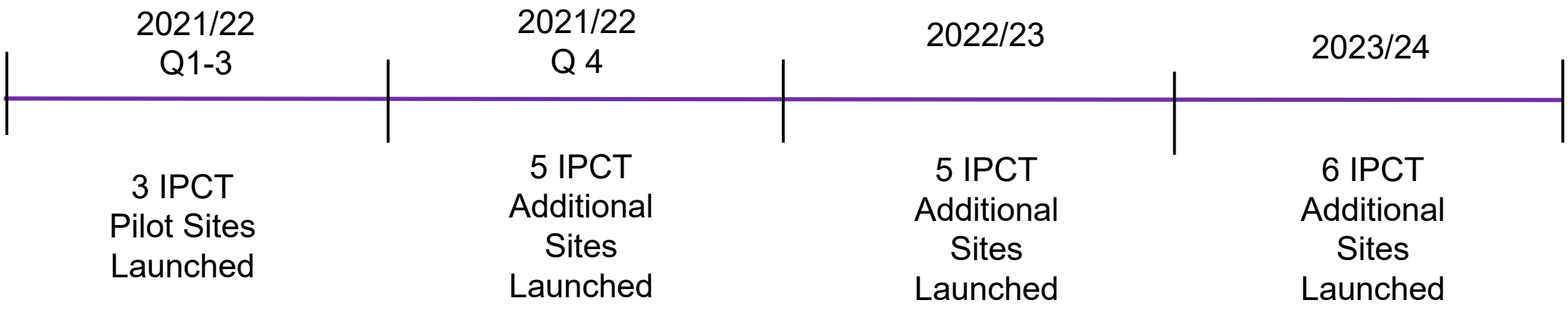
Road Map to Full Implementation of the IPCT Model in GW OHT

Validate Assumptions:

1. All IPCT sites will be launched by the end of 2023/24
2. Implementation (see slide 6) will take 2 years at each site
3. GW OHT will have the IPCT Model fully implemented in all ~16 IPCT sites by the end of 2025/26



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