People-Centred Health Home receives endorsement as the foundation for building our FLA Ontario Health Team

At the heart of the foundation for building our Frontenac, Lennox & Addington Ontario Health Team (FLA OHT) is the concept of a *People-Centred Health Home*. This concept, along with the supporting principles, will help inform and guide the work towards ensuring that all members of our community have equitable access to a diverse array of community-based health services.

In October, the *People-Centred Health Home* working definition was presented to the Community Council and FLA OHT leadership where it was enthusiastically embraced and endorsed as the foundation for FLA OHT work going forward.

"Early on in discussions with our Health Home Support Structure group it became very clear that we didn't all have the same vision of what a Health Home is. Based on the lived experiences of many of our members we came to appreciate the complexity of issues people were facing in accessing an equitable and inclusive health system," says Dr. Glenn Brown, a primary care physician and co-chair of the Health Home Support Structure group. "We then looked at the literature, continued conversations with our lived experienced advisors and, building from the academic and community work that had already been done on the concept of the Health Home, we were then able to formulate our own vision which has been endorsed as our working model going forward."

With this endorsement, the *People-Centred Health Home* that our OHT is working to create is defined as:

"… the first point of contact within the health-care system that provides people with safe, continuous, person-centered, comprehensive health and wellness services. It includes fast, easy access, seamless service coordination and navigation support to keep people safe and healthy in their homes and communities."

A central concept of the *People-Centred Health Home* is that it is person-centered; meaning that we must think about the person at the centre of the health-care system and how we can wrap necessary services around that person to meet their individual needs.

"From a health policy point of view the concept of a Health Home can be best understood as being different from our present approach of always thinking, planning and delivering services as separate institutions in our health-care system whether it's a hospital, doctor's office, community pharmacy or mental health service, to name a few. We recognize that these services are fragmented and siloed by nature and result in inefficiencies in providing care and results," says Dr. Brown. "If we can achieve the vision of a Health Home with the person as the unifying principle at the centre and wrap services around the person who needs them, we can achieve improvements and efficiencies that will help us address some of the gaps in care that we see in our communities."

With the definition of a *People-Centred Health Home* in place, each of the working groups and partners are now being asked how the work that they are involved with fits with the model, and how

they can help bring the vision of the Health Home to life. To help inform this thinking there are seven principles that have been created to help guide how we will achieve this vision.

The seven principles for our working definition of a *People-Centred Health Home* are:

1. Equitable Care

Everyone in our region is part of a Health Home. Equity implies that we identify those in our society who face huge obstacles in receiving care. In a *People-Centred Health Home* we will use our resources to address these obstacles and achieve equity, allowing everyone in our community to have support in achieving their health goals.

2. Accessible Care

Health care needs to be fast and easy to access. We have a bold vision that everyone in the FLA-OHT should belong to a *People-Centred Health Home*. At the same time, we recognize that a large portion of our regional population does not currently have a primary care physician. To address this, we need to help providers work to their full scope and help ensure that we eliminate barriers to deliver equitable, respectful and culturally appropriate care and services, including to those who identify as Indigenous and Francophone.

3. Connected Care

We need to leverage digital tools to share health information with individuals, care partners and providers in the circle of care in a streamlined and simplified way, including providing individuals with access to their own health information.

4. Collaborative Care

All of your health care providers work as one team. It is vital that we continue to build on the strong relationships and partnerships that currently exist among our health care providers and services. We must continue to seek opportunities to work with other individuals and organizations in new ways in order to meet the needs of the persons served.

5. Holistic Care

We treat people, not just problems. We must take a whole-person approach to our delivery of health care and understand that the health needs of individuals are unique and multifaceted. They require that we address physical, mental, emotional and spiritual needs, a philosophy aligned with the medicine wheel that features in the Indigenous view of health and wellbeing.

6. Accountable Care

We're responsible for health-care quality, experience and outcomes. We need to make sure that the right services are being provided at the right time and that they are having the impact on health that we intend. We will incorporate appropriate information management tools to support collecting and sharing relevant patient information through information technology to ensure continuity and accountability of care.

7. Continuity of Care

Health care is delivered over the life span. We must foster long-term relationships in the care team and encourage the development of these connections.

“These principles, along with the working definition of a *People-Centred Health Home*, are the foundational building blocks of what we want to achieve in our Ontario Health Team,” says Dr. Brown. “In our work going forward we will make sure that these have meaning in and connection to our priority projects and are supported and nourished in our Ontario Health Team.”

Up next, the endorsed *People-Centred Health Home* working definition and principles will be taken to the November 25th Partnership Council Town Hall to create common understanding of the model as a basis for further engagement with each sector on where they fit within this model and how they can contribute to the creation of *People-Centred Health Home*s in our OHT. These conversations will help us identify priorities for action which will be used in the development of the first strategic plan for our FLA OHT.

To see the full *People-Centred Health Home* presentation please click here.