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Transforming Primary Health and Community Care

Webinar Q & A - Sept. 13, 2016

1. **Q. Health Links created local level Community Engagement Panels. Are we to disband those panels (even if they are local level patients/caregivers) who can help co-design at the local level?**

   A. Health Links have an important role in coordinating care for complex patients. This work will continue within each of the five (5) sub-regions as part of our primary care strategy across the Toronto Central LHIN including engagement with patients, clients and caregivers at the local level.

2. **Q. Will the Regional table scheduled for the end of October include provincial mandates as well?**

   A. Toronto Central LHIN is in the midst of establishing a framework to lay out what elements will fit within the Regional framework model. The intent is to capture those services that span across the LHIN geography and are required to deliver population-based, integrated, coordinated care across the system. The development of this regional framework is in direct response to the feedback and input received during consultations with providers, partners, and patients held earlier this year, and will include provincial and specialty programs.

   A working group will be established with an initial meeting planned for Fall 2016. If you are interested in participating or wish to provide any feedback, please contact our lead, Gillian Bone, for this regional work.

3. **Q. Are you able to share more about the Community Leadership Expression of Interest (EOI) and will there be an alignment of Community Support Services and Community Mental Health and Addictions?**

   A. Our community partners are integral to achieving our *One Team, One Plan* approach at the Toronto Central LHIN. In the coming weeks, we will be recruiting five (5) or more leadership positions that will strengthen the voice and contribution of Community Support Service (CSS) and Community Mental Health and Addictions (CMHA) services in the development of key strategic priorities of the LHIN such as Local Collaboratives, Integrated Primary Care, and Integrated Community Care.

   These leadership positions will act as advisors to the Toronto Central LHIN and will require a commitment of approximately one (1) day per week. When released, the EOI will be posted on our Toronto Central LHIN website.

4. **Q. Will you be developing a lead for inter-professional care given that this is a priority area?**

   A. Access to Inter-professional Teams is a primary care priority project with Dr. Geordie Fallis as Primary Care Clinical Lead. In our engagement activities with physicians and inter-professional team members, it was identified that there are a large number of practices who serve complex patients and do not have access to inter-professional team supports. Dr. Fallis is leading a working group to improve access to inter-professional care teams for practices and patients who need these core supports.

5. **Through this plan, quite clearly, priorities should be set locally and yet, PSW training priorities are set by MOHLTC. I see this as a barrier to moving forward as a team for the benefit of patients and quality of care.**

   A. In developing our Toronto Central LHIN Strategic Plan 2015-2018. the legislative and policy framework set by the Ministry of Health and Long Term Care (MOHLTC) was considered. The government's Patient's First Action Plan sets out the priorities for health care across the province, and the focus of the Toronto Central LHIN will be ensure that patients, clients and providers are able to deliver and receive equitable access to care, better integrated and coordinate care in their community, and support people and providers to be informed**.**

6. **How will we engage with marginalized and vulnerable populations?**

   A. One of the areas that we really need to focus on is using available data and working with Public Health. We have a unique mandate and opportunity, when you combine both the responsibility around data-driven planning and the responsibility for engaging communities in order to better understand where need exists. Better understanding the needs of vulnerable populations will require access to the most robust set of data available and the skills to break that data down into meaningful segments within the sub-regions. This involves looking specifically for trends among certain populations that have we know have less access to care and poorer health outcomes.

   Once these populations have been identified, then we will need to think about what the solutions might look at with the partners who are at the sub-region level. This is a really exciting opportunity to work with Public Health as they have a lot of experience and expertise in this particular area, especially in engaging targeted populations to understand what the health experience looks like on the ground. Public Health also have a broader reach in terms of established connections with the social services at the municipal level and other networks that can really make a difference on the social determinants of health. We are well positioned to work together to identifying marginalized population and actually finding solutions that are effective in improving their access to care.