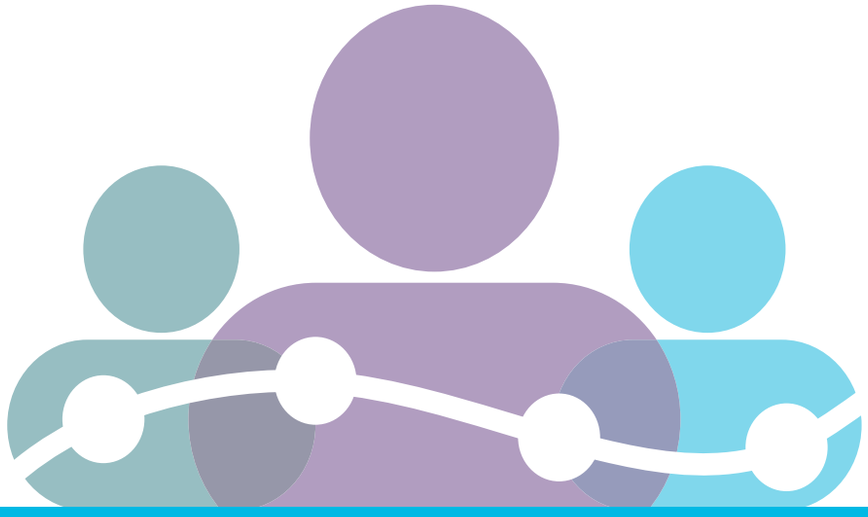
Stronger Connections **Better Health**



Primary Care Strategy Update

Summer 2017

Ontario
Toronto Central Local Health Integration Network

Get Involved: Connecting Primary Care through Networks

Primary Care Providers have an important and unique perspective on the health care system, which positions them to drive integration and coordination of the patient journey. Local primary and community care committees were established in each sub-region to guide, develop and implement improvements locally that will improve access and care coordination across the health care system overall. These committees are a first step to engage all the primary care providers within the Toronto Central LHIN and build networks at the sub-region level that include all care sectors.

If you are interested in learning more about the Toronto Central LHIN's Primary Care Strategy, want to engage or have feedback, please contact the sub-region Primary Care Clinical Lead in your Sub-Region listed on pages 9-10.

Dear Partners,

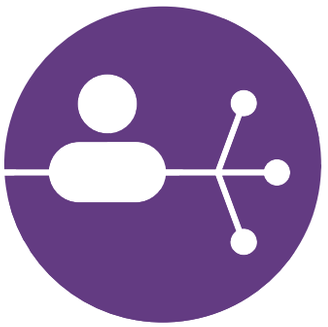
The Toronto Central Local Health Integration Network (LHIN) plans, funds and integrates heath care at the local level to effectively respond to the distinct needs of the diverse communities we serve. And one of the things our communities need is a strong local primary care system. Transforming primary and community care is one of the Toronto Central LHIN's strategic priorities, one that includes improving access to care for patients and improving connections between providers and services. This is critical to an effective and sustainable health care system, and getting there requires partnership and collaboration. Health care planners must collaborate and engage primary care practitioners, health service providers and their patients. Engagement of doctors, nurse practitioners and other community providers is important to ensure they are at the table to bring forward innovative patient-centred solutions and to co-design an integrated system that works on the ground, in the community—and for the community.

Physicians, community health centres, community support agencies, hospitals and other health care providers are well positioned to work together to build a coordinated primary care system that more effectively meets the needs and improves the experience of patients and providers. Looking at populations, or taking a sub-region approach, will help us to better understand the needs of each community. This will give us the tools we need to build system level solutions.

This update summarizes the work of the Toronto Centre LHIN's Primary Care Strategy that has taken place to date, which has been expertly guided by local leadership and partnerships that span across all care providers. Over the last year the Toronto Central LHIN's Primary Care Clinical Leads have been working to build relationships and to support providers across the LHIN. Trust takes time to build and through the priority projects enclosed, we are working to collaborate on solutions that are the first steps necessary to ensure the patients, clients and family members benefit from a person-centred, integrated health care system that provides high quality primary and community care.

Dr. Philip Ellison
Physician Advisor, Primary Care Strategy

In This Update:



1 ATTACHMENT, ACCESS AND CONTINUITY OF CARE

Health Care Connect Care Connector Expansion

Health Care Connect refers Ontarians who do not have a physician to a family health care provider who may be accepting new patients. This program has been in place since February 2009 and in that time over 27,000 Toronto Central LHIN patients have registered with Health Care Connect. Of those patients, over 90% have been successfully referred to a primary care provider who is accepting new patients.

To build on the successes to date, the Toronto Central LHIN will fund additional care connectors to work with the local Primary Care Clinical Leads at the sub-region level and assist local residents with finding a provider.

Mental Health Care Connector Pilot Project

Through consultations with providers, the LHIN understands that primary care providers can have difficulty accepting new patients due to limited resources to find care for patients with significant mental health challenges.

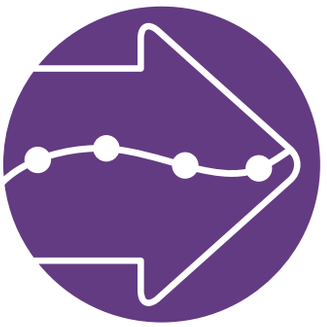
Based on population and provider data, a pilot project in the East Toronto and West Toronto has been approved to hire a mental health worker in these sub-regions to work with a number of physician groups without access to in-house mental health services, with the goal of servicing these patients and expanding capacity. The project will be evaluated after a year to assess the impact.

Transitioning Health Links

Toronto Central LHIN successfully transitioned their nine previous Health Link geographies to align to the five local sub-regions. The Health Link approach is one in which local health providers are working together to provide coordinated care and improved transitions for patients with complex needs. In 2016/17, through implementation of the Health Link approach by primary care, hospital and community partners, 2,977 coordinated care plans were initiated for patients with complex health needs.

To support the implementation of a consistent approach for identification and care plan development for patients with complex needs across the LHIN, an interim work group has been established with representation from the Primary Care Clinical Leads, Community Support Services (CSS), Community Mental Health and Addictions Services (CMHA), and home care services to develop recommendations.

As part of the transition, several pilot projects that had been initiated through Health Links are being spread across the LHIN. For example, in Mid-East Toronto a cross-sectoral team of hospital and community partners was selected to participate in the IDEAS Advanced Learning Program (designed to equip health care professionals with knowledge, practical skills and tools to lead quality improvement initiatives). This project focused on the implementation of an inpatient screening tool and initiation of a referral to community transitional coordinators and led to improved identification practice and transitions from hospital to home.



2 ACCESS TO INTER-PROFESSIONAL TEAMS

The provision of comprehensive health services to patients by multiple caregivers who work collaboratively to deliver quality care can improve outcomes for patients. It has demonstrated success in addressing the medical and psychosocial needs of patients, particularly those facing unique challenges and barriers.

New Interprofessional Care Teams

The Toronto Central LHIN assessed access to interprofessional care across the region and the East Toronto and West Toronto sub-regions were identified as areas in most need of improved access. In addition to expanding access for local residents, the implementation of new care teams will serve to inform a LHIN-wide strategy on how to further align interprofessional care to the specific needs of local communities.

Interprofessional Care in the West Toronto

In partnership with Unison Community Health Centre, the primary care team in West Toronto will be supported by a new interprofessional care team consisting of a registered nurse, a social worker, a community addictions worker and an outreach coordinator. The team will provide collaborative care to a neighbourhood that demonstrates some of the highest prevalence rates of diabetes, hypertension and mental health and addictions disorders in Toronto.

Advancing Interprofessional Primary Care in the East Toronto

This initiative established a new interprofessional primary care team consisting of one registered nurse and three registered social workers who are working directly with a primary care practice serving high-needs patients. This population includes recently homeless adults, people who experience a low continuity of primary care and social supports, low income and poorly attached adults transitioning into housing, adults in need of mental health and addictions supports, and seniors with psychogeriatric needs living alone.

Expanding the Solo Practitioners In Need (SPiN) Initiative

Solo Practitioners in Need (SPiN) is a referral program that allows family physicians without access to interprofessional teams to connect their medically and socially complex patients to services available within an established network of community health centres and other community service organizations.

In addition to extending access to important supports for patients, SPiN also promotes meaningful collaboration between family physicians and local community health centres.

Building on the success of SPiN, an expansion is underway to provide access across all sub-regions by adding the remaining 9 of 17 community health centres within the Toronto Central LHIN. This initiative aims to increase the number of participating family physicians from 55 to 115, and to extend access to over 350 new patients.

Telemedicine IMPACT Plus (TIP)

Accessed via a centralized referal system, Telemedicine IMPACT Plus (TIP) uses secure telemedicine technology to deliver a patient-focused, interprofessional care planning session via video conference. A TIP nurse collects required information from the primary care provider and meets with the patient to assess their health history.

During this assessment, the TIP nurse identifies issues and determines which team would be most relevant for the care of the patient. The nurse will then schedule a videoconference consult session with the patient, the primary care provider and the relevant interprofessional care team members, assembled at different locations. The TIP nurse then supports the patient and their primary care provider in implementing the coordinated care plan generated during the session.

Typical TIP patients have multiple chronic conditions, are taking a number of medications and often have co-existing mental health and socioeconomic challenges. These individuals will often turn to local emergency rooms when the right kind of services are perceived to be inaccessible.

Historically, the four TIP nurses supported up to 25 clinics a month across the Toronto Central LHIN, and last year exceeded their target of providing support to 100 complex patients last year. To ensure equitable access for patients and providers across the Toronto Central LHIN, a fifth TIP nurse has joined the t eam, resulting in coverage now being available across the LHIN.

3 ACCESS TO SPECIALIST CONSULTATIONS

During the Toronto Central LHIN's consultations with over 250 primary care providers, improving access to urgent and routine specialist consults was raised as a significant priority. Difficulties accessing specialty consults in a timely manner contributes to:

- **Delayed treatments for patients that could result in deteriorating conditions or adverse events**
- **Increased use of emergency departments**
- **Inefficient use of primary care providers' time searching to make multiple referrals, and managing repeat visits to address the condition**
- **Long wait times also impact on specialist efficacy, patient experience and outcomes**

In response to the identified obstacles, two projects are underway that will leverage partnerships and technology in improving access to specialist care.

Development of a Specialist and Services Directory

Partners from across the health care system, with the support of the LHIN, are creating an electronic Specialist and Services Directory that provides primary care providers with comprehensive, accurate and up-to-date information on specialists and other services available within the Toronto Central LHIN. The solution will be accessible through the web and will feature search capabilities, greatly enhancing primary care providers' ability to help their patients in accessing specialty care, where and when they need it.

The Directory is scheduled to be implemented by Spring, 2018. In addition to making available an up-to-date directory, we are in the process of planning for the implementation of an electronic referral solution that will help make it easier to send referrals to and/or consult with specialists.

SCOPE Expansion (Seamless Care Optimizing the Patient Experience)

Seamless Care Optimizing the Patient Experience (SCOPE) is a partnership between University Health Network (UHN), Women's College Hospital (WCH) and the LHIN's Home and Community Care staff that matches primary care needs with hospital and community services, identifies gaps for the most high-needs patients, and streamlines access to a number of sub-specialities. Based on active, grassroots co-design with 140 Toronto family physicians, SCOPE offers a virtual inter-disciplinary team with real-time access to specialist consultation. Through a dedicated telephone number (**416-217-3820**), the SCOPE initiative provides registered primary care physicians access to a:

- **Nurse navigator and care coordinator to assist with system navigation**
- **General internal medicine specialist for expedited consultations**
- **Diagnostic imaging consultant for advice on imaging**

This team is currently based out of UHN in the Mid-West Toronto sub-region and St. Josephs Health Centre in the West Toronto sub-region. The approved expansion will see similar teams implemented at the remaining three sub-regions across the Toronto Central LHIN. In addition to promoting enhanced care for patients, the expansion of SCOPE will continue to improve linkages between community-based physicians, hospitals and local resources.

4 HOSPITAL DISCHARGE PLANNING

Continuity of care involves coordinating the care and experience of patients as they navigate the health care system. A lack of continuity can lead to unnecessary repetition of diagnostic tests, inappropriate medication prescriptions, and the incomplete and/or inaccurate transfer of information. This ultimately has the potential to negatively impact patient care.

The period immediately following discharge from a hospital is a potentially high risk and vulnerable point in time for some patients. In addition to timely primary care follow-up during this post-discharge period, it is important that the primary care provider understands the circumstances leading up to the hospital admission, what happened during the patient's hospital stay and the details involving discharge.

Admission into the hospital is a key point in the patient's journey, it is important that the family physician is notified of the admission. Of equal importance is ensuring that hospital providers have ready access to important patient health information. Before leaving the hospital, community supports should be identified and arranged prior to discharge. A "warm hand-off" approach should be used whenever possible to make the transition back to the community comfortable and positive. In addition, patients and caregivers should already be aware of – and understand - any changes to their care plan and/or next steps. Once a patient leaves the hospital, the family primary care provider should be notified of the discharge and made aware of any changes (e.g. medication) to prepare for the first post-discharge follow-up visit.

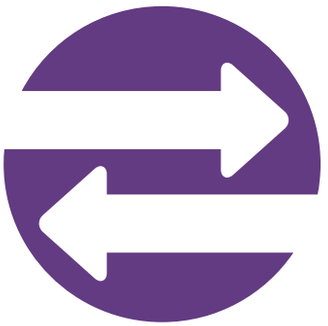
Underlying this continuum are several important elements that include technology, training, quality assurance and process.

Hospital Resource Manager & eNotification

Primary care providers need to know when a patient has been admitted or discharged from the hospital. It is also important that the hospital is equipped to share patient information with the doctor in a way that is timely and complete.

Hospitals have traditionally sent reports by mail or fax, which may result in delivery delays and legibility issues. Hospital Resource Manager enables doctors using certified electronic medical records to receive patient reports electronically, a practice that promotes timely delivery and helps avoid the legibility issues associated with faxing.

Electronic notifications (eNotifications) sends an electronic notification to the primary care provider (and home and community care services at the LHIN, when applicable) whenever a patient is admitted to the hospital. In addition to promoting better continuity of care and prompting the appropriate scheduling of a follow-up visit by the doctor, this also facilitates collaboration and coordination among community providers. To date, seven Toronto Central LHIN hospitals have implemented Hospital Report Manager and three are now live with eNotificiations. Universal adoption and implementation is currently underway.



5 SECURE COMMUNICATION

ADVANCING SECURE COMMUNICATIONS

Secure communication between providers facilitates the timely transfer of personal health information to inform care decisions, expedite follow-up and reduce duplication of tests. Secure communication of personal health information between providers and patients facilitates engagement in care planning, improves follow-up, adherence to the care plan and can streamline patient access to information and appointments with their primary care provider.

OneID Bundle:

The OneID Bundle project aims to work with provincial partners (eHealth Ontario and OntarioMD) to streamline the registration processes for ConnectingOntario, ONE Mail and eConsult to make it easier and faster for physicians to use these technologies in their practices. The project also includes an adoption team that will support at least 300 physicians in successfully adopting these technologies this year.

> **ONE Mail** is an encrypted mail service provided by eHealth Ontario which allows registered health care professionals to share patient information quickly, confidentially and securely. This allows providers to securely communicate and collaborate on a patient's care.
>
> **eConsult** is a secure online tool developed by Ontario Telemedicine Network that enables primary care providers to electronically send a question to a specialist to inform clinical decision-making without sending the patient to see the specialist in person.
>
> **ConnectingOntario-GTA** is a regional electronic health record system that provides clinicians and care providers access to acute and community care data to improve the timeliness of care decisions, reduce duplicate tests and procedures and better support care transition points. Connecting Ontario-GTA currently is a hub with health information on approximately 6.75 million Ontarians. Laboratory information, diagnostic imaging reports (and the images themselves), Ontario Drug Benefit drug registry information, and potentially other categories of information can be accessed.

My Chart Expansion:

MyChart is a personal online health management and continuity of care record service created by Sunnybrook Health Sciences Centre, designed specifically for patients and, through them, for families, clinicians and personal care teams. MyChart enables patients to access their own clinical records and create and manage their own personal health information, all in one record. Patients can grant access to the record to caregivers from anywhere using the internet.

Sunnybrook is helping implement MyChart to expand to two new hospitals (St. Joseph's Health Centre and West Park Healthcare Centre) next year. The project also includes recommendations for further expansion and the collection of patient feedback about their experience using the platform.

Secure Patient Messaging:

Difficulty in securing appointments due to busy schedules for primary care providers negatively impacts access to care and patient satisfaction. In addition, requiring in-person appointments for issues that can be addressed through secure electronic communications can be an inefficient use of both the patient's and provider's valuable time.

This project aims to assess existing gaps in communication, understand currently available solutions in the market, explore policy and privacy frameworks, and evaluate potential return on investment of secure patient and provider communications. This work will enable the LHIN to make informed decisions as to how to best enable secure communications between patients and providers.

Local Expertise Makes a Difference: Our Primary Care Clinical Leads:

Primary Care Clinical Leads have been recruited into leadership positions in the five sub-regions within the Toronto Central LHIN with teams to support local engagement efforts. These Leads partner with primary care providers, other local health service providers and organizations to improve access to care, co-ordination and service integration.

WEST TORONTO

Dr. Don Smith- Primary Care Clinical Lead
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- Family physician at the Village Family Health Team

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MID-WEST TORONTO

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- Associate Medical Director at University Health Network

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Dr. Jocelyn Charles- Primary Care Clinical Leal
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• Chief of the Department of Family & Community Medicine and Medical Director of the Veterans Centre at Sunnybrook

Dr. Yoel Abells- Primary Care Clinical Lead
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• Dr. Yoel Abells is the Medical Director of the Forest Hill Family Health Centre.

Kitty Liu, Primary Care Manager:
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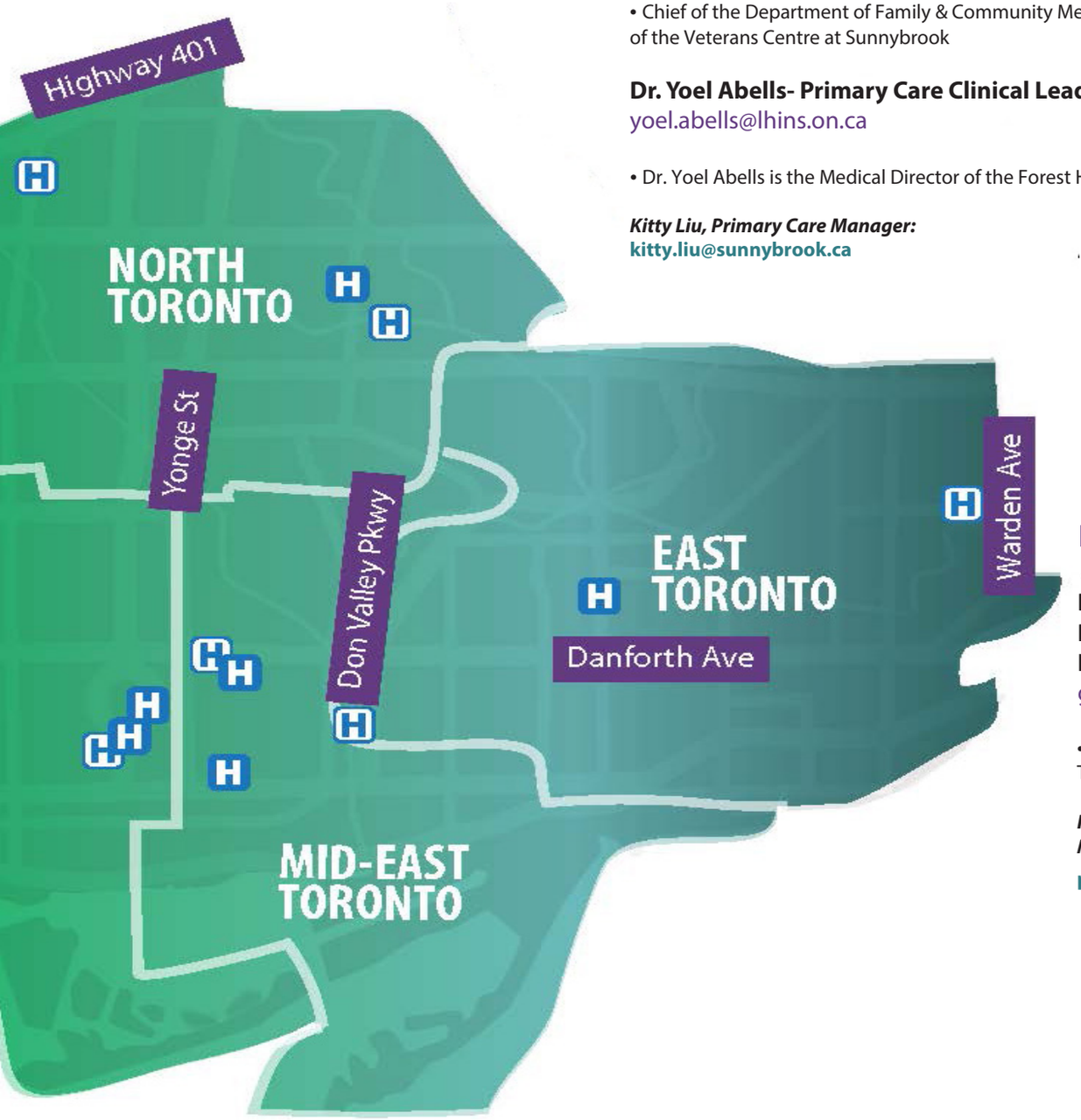

EAST TORONTO

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MID-EAST TORONTO

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STRONGER CONNECTIONS BETTER HEALTH

THE FUTURE OF HEALTH CARE IS LOCAL

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