International Journal of Integrated Care

Charles, J et al 2018 Building a Population-based Integrated Health System on a Foundation of Primary Care in Toronto. *International Journal of Integrated Care*, 18(S2): A88, pp. 1-8, DOI: dx.doi.org/10.5334/ijic.s2088

CONFERENCE ABSTRACT

Building a Population-based Integrated Health System on a Foundation of Primary Care in Toronto

18th International Conference on Integrated Care, Utrecht, 23-25 May 2018

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Introduction: Toronto, population 2.79 million 5.5 million in surrounding area, is one of the world's most multi-cultural cities with over 140 languages spoken, 47% from visible minorities and home to 30% of immigrants to Canada. Access to health care services varies significantly in Toronto based on neighbourhood and location of provider. There are multiple primary care models not connected with other health services and large numbers of non-Toronto residents accessing primary care in the city. The Toronto Central Local Health Integration Network LHIN is responsible for planning, funding, and integrating local health services.

Description of Practice Change: The Toronto Central LHIN's Primary Care Strategy aims to ensure all residents have equitable access to a primary care provider and are able to receive timely care. Five Sub-Region teams Primary Care Clinical Lead, a local hospital executive and sub-region manager were created to engage primary care providers and work together with the citizens of those communities, to understand local needs, identify resources to be leveraged and enhanced, and evaluate progress towards a more integrated system.

Aim and Theory of Change: Beginning with identified health and social needs and using existing health care resources, care will be tailored to specific community needs for optimal population health outcomes, patient experiences and efficiency.

Targeted Population/Stakeholders: Following consultations with over 200 family physicians the LHIN identified five priority projects: improving primary care access and continuity, enabling secure communications between providers and with patients, improving timely access to discharge summaries, and enhancing access to urgent specialist consultations and needs based inter-professional teams.

In each Sub-Region data analyses of demographics, immigrant status, languages spoken, income levels, chronic disease prevalence, mental health conditions, living alone and health service utilization has identified "high needs" areas where new or expanded primary care interprofessional teams are needed to improve access. Two teams have been added to very high needs neighbourhoods and 6 more are planned.

Timeline: This multi-year Primary Care Strategy is in its second year with a workplan in place for the next 2 years.

Highlights: Investments in communication tools, discharge planning initiatives, specialist directory, care connectors/coordinators, and mental health workers were guided by Primary Care Leads and Sub-Region teams. Grouping services with one number to call, and using telemedicine to link patients, providers and teams TIP are some efficiencies expanded to meet needs. Going forward sub-regions will also invest in co-design/co-production planning with citizens and community providers in high-needs neighbourhoods.

Sustainability: This primary care strategy has been developed with the key goal of building a sustainable integrated system.

Transferability: The approach to population-based primary care and integrated health services planning using and expanding on existing resources is a methodology that is fully transferable to other jurisdictions and settings.

Conclusions & Lessons Learned: Local health care planning tailored to identified population needs with engaged primary care providers and local citizens, linked to hospital and community providers and supported by tools and systems has the potential to improve patient outcomes and experiences efficiently. Lessons learned are part of iterative local planning.

Keywords: health equity; access to health care; interdisciplinary health team; intersectoral collaboration