Understanding Transitions in Care:
From the Patient & Caregiver Perspective

*In collaboration with the Toronto Central LHIN
Citizens' Digital Health Working Group*

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Acknowledgements

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Introduction

The patient and caregiver journey through the health care system has long been a complex one. In Ontario, Canada's most populated province, over 13 million people are challenged with navigating a fragmented system that lacks the integration, from both a care coordination and information sharing perspective required to support quality care.

Transitions in care continue to be a pain point for patients and/or caregivers as the journey is often neither seamless nor coordinated, leading to an overall care experience that is confusing to navigate and is less than ideal in supporting quality care.

> **Definition of Transitions in Care:**
> *Any change in an individual's care needs due to a change in an individual's state of health, whether it means a movement between care settings (such as hospital to home), sector-to-sector, organization-to-organization, and service provider-to-service provider.*

In its role as the Centre of Excellence for Digital Health Delivery for the Toronto Central and Central LHINs, UHN Connected Care has been tasked with developing a current state understanding of the patient and/or caregiver experience surrounding transitions in care.

In collaboration with the Toronto Central LHIN Citizens' Digital Health Working Group, this report provides a framework to assist in understanding the care experience as it relates to transitions in care. In addition, it highlights the strengths and gaps that exist in delivering seamless care and recommends key priorities, specifically as it relates to digital health for the region.

Understanding the Patient & Caregiver Perspective

In order to understand the current patient and caregiver experience regarding transitions in care, UHN Connected Care engaged members of the Toronto Central LHIN Citizens' Digital Health Working Group.

This engagement consisted of initially conducting individual interviews to understand the care experiences each individual had faced as a patient and/or caregiver in the current health care system. Following these interviews, we facilitated group sessions to identify the patient and caregiver perspectives that resulted in the following deliverables:

1. *Patient/Caregiver Transitions in Care Framework*
   - A co-designed model that outlines an individual's health and care needs over time, as well as provides a care pathway that summarizes the interactions where individuals are dependent on the health system and other social supports; the multitude of factors that impact a person's health and wellbeing are equally important to the overall experience.

2. *Strengths and Gaps in Current State Transitions in Care*
   - Summary of strengths and gaps regarding the current state of transitions in care based on themes identified from interviews and facilitated group discussions.

3. *Patient and Caregiver Recommendations to Enable Seamless Transitions*
   - Summary of recommendations to achieve a more seamless care experience, including key priorities citizens would like to see the LHINs focus efforts on to support the digital health agenda. While this project is centred on understanding digital health needs, it was important to understand the bigger experience in order to ground

recommendations and digital priorities. As a result, the report provides broader recommendations for the health system to consider in addition to next steps specific to digital health.

1. Patient/Caregiver Transitions in Care Framework

In order to get a better understanding of the patient and caregiver experience with current state transitions in care, it is important to understand the influences that impact an individual's dependency on the health care and social support systems over the course of one's life. Through a co-design process, the Patient and Caregiver Transitions in Care Framework was developed as a way to understand patient/caregiver experiences and their interactions with the system to help identify where the strengths and gaps in care can, and do, occur.

Guiding Principles to Support the Transitions in Care Framework

To capture the current state patient/caregiver experience in transitions in care, individual interviews were conducted with some members of the Citizens' Panel Digital Health Working Group. Throughout these interviews, certain guiding principles emerged. In order to be able to truly represent the current and future needs of a more integrated care experience, the framework must reflect or allow for the following:

- *Patients and caregivers* must be *treated as part of the care team*, all working together in collaboration with care professionals.
- *Health and care experiences* take place *over a life time*
    o Recognition changes in a person's state of health are also part of the transition experience.
- *Recognition that no two experiences are alike*
    o People's unique care needs will result in different points of views and experiences within the healthcare system. The most difficult transition experiences are often when individuals are dealing with more than one chronic health condition and have complex health and care needs.
- *Understanding the multitude of factors* that impact an individuals health and care *that fall outside of health care*, such as socioeconomic status, literacy and language barriers, housing situation, and gaps in employment;
    o Discussions to date are often too simplistic and still focus on the health "system" rather than the whole person.
- *The different options available* to patients and/or caregivers to choose the care path that reflect their needs and desires
    o The support/services that are desirable by the patient and/or caregiver may fall outside of the services offered or funded by the health "system"; these desirable support/services need to be coordinated with the services offered or funded by the health care system.

Understanding Life Flow & Dependency on Health and Social Care Systems

In conducting the individual patient and/or caregiver interviews, it was evident that no two patient stories are the same. However, the group felt that there are generally some consistent features in each person's stages of life story where their dependency on the health care and social support systems are common – leading to the development of the term "life flow."

Building on the seminal work done by the by the Centre of Excellence on Partnership with Patients and the Public –Régie de l'Assurance Maladie du Québec (2018), the "Life Flow Pathway" model (**Model 1**) illustrates the various stages of life in the circles, with the dotted line depicting the general usage patterns when it comes to health and care needs. The dotted line does not represent all cases, but simply illustrates that in general, there is a greater

reliance on support needed at the beginning and end of life, as well as when complex chronic illnesses occur.

Interactions with health care and social support systems are influenced by the type of condition, personal support, and social determinants of health that surround each individual. The group stressed that the issues of social determinants needed to be added to Life Flow Pathway because health requires more than just medicine and clinical care. According to data from the [Centre for Disease Control and Prevention](#) in the US and the [World Health Organization](#), medical care only accounts for 11% of overall health.

Model 1 – Life Flow Pathway
Adapted from the Quebec Patient Partnership Model
(Centre of Excellence on Partnership with Patients and the Public)
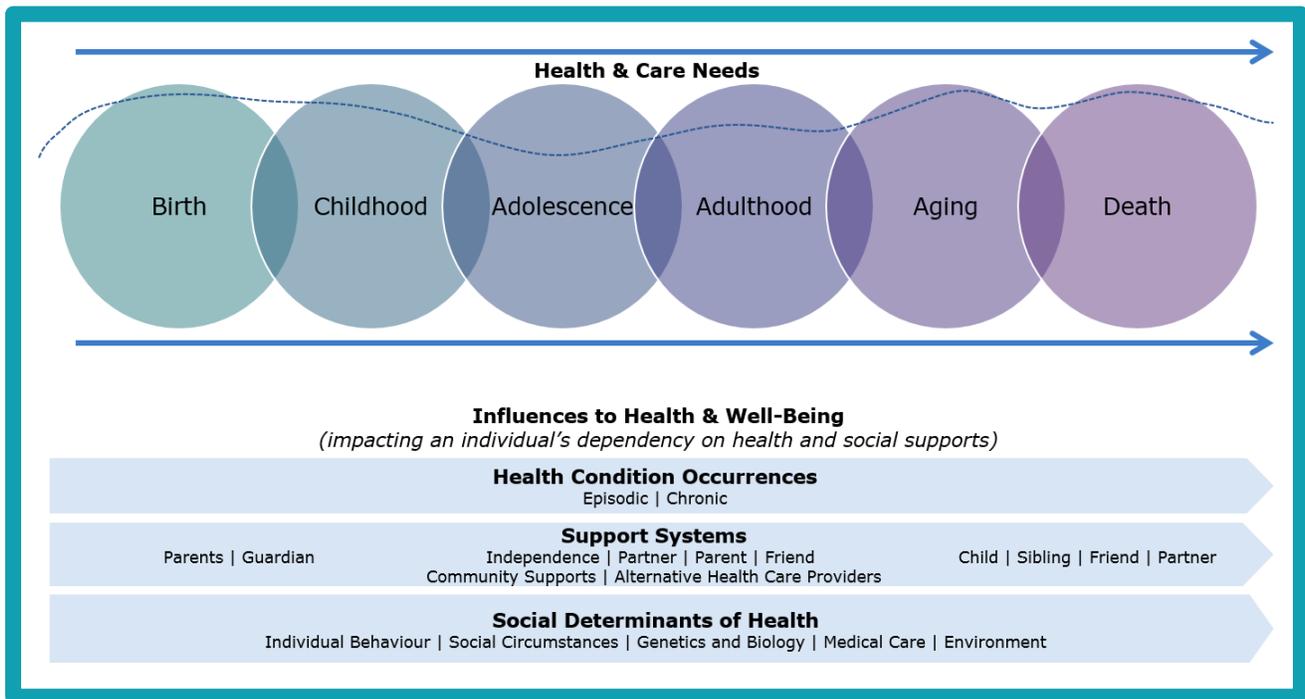
Understanding the Patient and Caregiver Experience

In a complex care system such as Ontario, defining anything as generic is challenging. The "Comprehensive Care Pathway" model (**Model 2**) captures key steps that are generally experienced by patients and their caregivers, when interacting with health and social care systems. This model should be broad enough to allow all individuals to see their care experience represented here – including negative interactions where an individual's health and wellbeing may be compromised, as well as positive interactions where an individual is trying to better their health and wellbeing.

Within the model, the inner circle speaks to the stages of interaction and is adapted from the Health Quality Ontario (HQO) model of [Coordinated Care Management](#). The outer, numbered circle, is adapted from the Quebec Patient Partnership Model, and this shows the steps that may occur in each stage.

Taking a co-design approach, the following key characteristics adhere to the guiding principles that were established and are critical differentiators to the contributions to date:

- The HQO model and the Quebec Patient Partnership model are complementary to each other, and the creation of this new, amalgamated model highlights the strength in both. The HQO Model primarily focuses on actions that a provider has to take, whereas the Quebec Patient Partnership Model speaks primarily, though not exclusively, to the patient/caregiver experience. As part of this work, the language was modified with the intent to be inclusive of social care system interactions as well.

- The model does not speak only to seeking medical care, but rather it speaks to caring for the whole person. This is reflected in the language used throughout. For example, "Step 2: Consult with a professional" can reflect a health care professional. Additionally, it may also refer to other service professionals that can provide essential form of social assistance that can impact health, such as a social worker or a professional that can help find suitable housing.

- In the Quebec Patient Partnership Model, it was noted that an individual would move directly from "Step 14: Living with New Normal" to "Step 15: End of Life." The patients and caregivers that informed our report felt that there was another option, which is that a new issue may arise, which would then initiate another experience on the pathway. The model has been adapted to reflect that nuance.

Model 2 – Comprehensive Care Pathway

Adapted from the Quebec Patient Partnership Model (Centre of Excellence on Partnership with Patients and the Public) & the Coordinated Care Management Model (Health Quality Ontario)
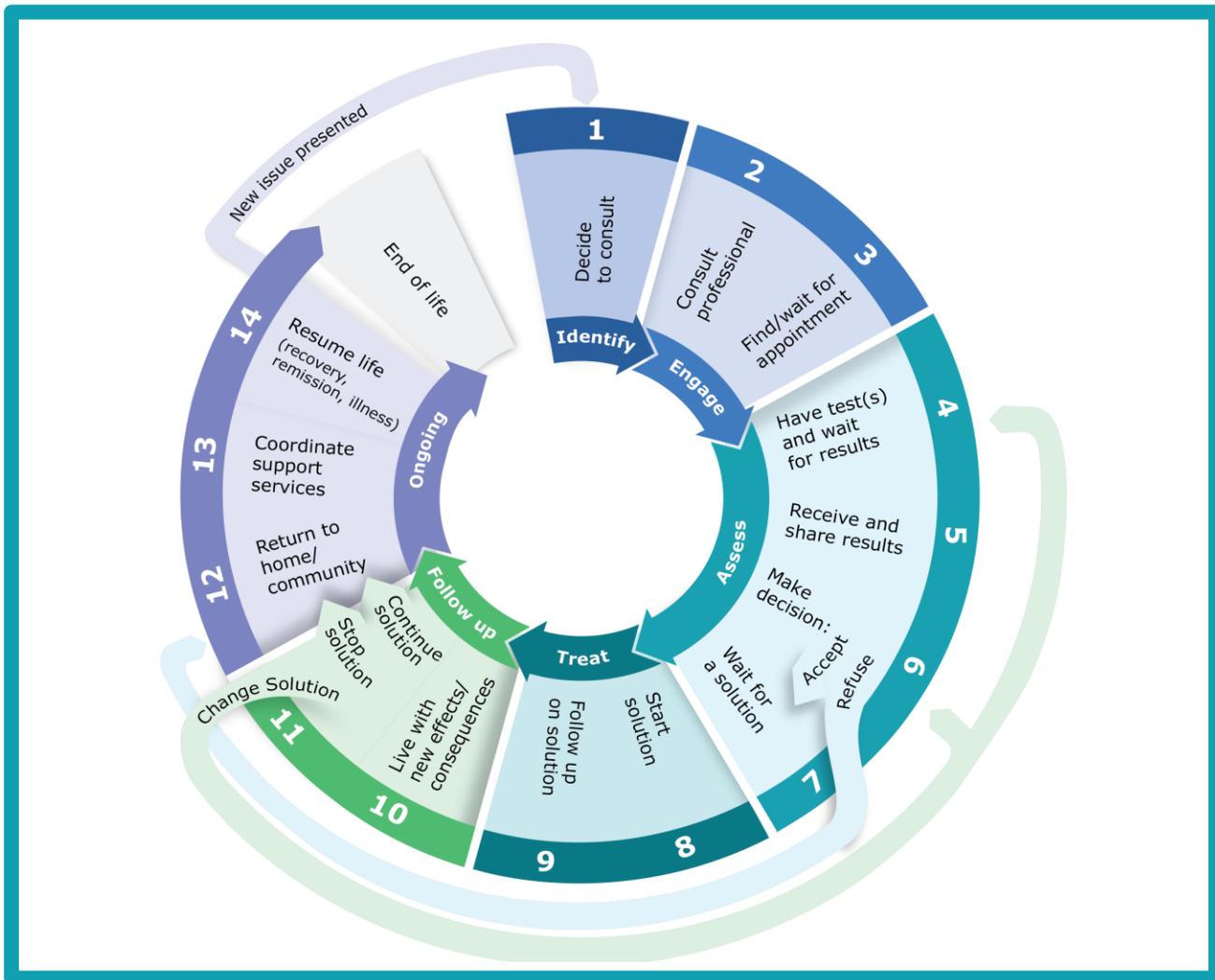
The above diagram is based on Vision for access to health information by the citizen, By the Centre of Excellence on Partnership with Patients and the Public –Régie de l'Assurance Maladie du Québec, 2018.

Using the Transitions in Care Framework

Patients and caregivers see the transitions in care framework as having a utilitarian use across the system. They ask that as care, policies, programs and systems are being considered, the pathway should be used to guide decision-making and prioritization.

2. Strengths & Gaps on Current State Transitions in Care

In conducting the patient and/or caregiver interviews, it was evident that transitions in care are in fact not seamless, and often lead to a poor care experience for patients and/or caregivers. The breakdown that exists with transitions is particularly problematic when it comes to the way care is coordinated, as well as how information flows to support (or more often does not support) continuity of care.

Strengths

From a strengths perspective there were not any areas that patients and caregivers could point to that were consistently done well across the health care system.

There were however some pathways that have shown some success in managing transitions of care more effectively. For example, patients with experience in the cancer system felt that care was more patient-centred, care professionals worked in a more team-based, integrated, and collaborative way, and that information was shared with patients and their caregivers. This allowed for the transitions to be much easier to navigate. In addition, programs that included the following characteristics were also seen as providing a better and more integrated care experience:

- Having a single-point of contact for care coordination, as well as additional follow-up support services. This is especially important for complex chronic illnesses with multiple co-morbidities that would require coordination between multiple care professionals and treatment plans
- Having a 24/7 support, such as a hotline
- Care professionals, including specialists, communicate with each other and work collaboratively to develop and deliver a patient's care plan
- Being connected to patient education classes and social support groups

Gaps/Opportunities for Improvement

Patients and caregivers identified many gaps and opportunities for improvement. The following represents identified themes related to transitions and subsequent feedback provided by patients and/or caregivers based on their individual experiences within Ontario's health care system.

Broad Themes	Patient and/or Caregiver Feedback
Primary Care Provider and Specialists	• Primary care providers often act as a "triage for referrals," and there are a few issues with how this referral process is executed. Firstly, primary care providers do not always conduct a follow up to ensure that patients have been successfully connected to the referred care provider. Secondly, the primary care provider is not always aware of the results of the patient's referral or the patient's most recent state of health. These affect the continuity of care • Patients are unsure of the role of the primary care provider and feel that there is a need for primary care providers to play a larger role in managing care coordination ("case manager"), with support of a Family Health Team-based practice • Patients whose primary care providers are part of a broader care team (Family Health Teams, Community Health Centres) feel they have better managed care and access to other health professionals

	and after-hours care, if needed. These are essential to receiving quality health care.
	• There is a lack of clarity as to who owns the coordination of patient care when there are multiple specialists involved. The care that the patient receives is siloed, which may result in the patient falling through the cracks with potentially catastrophic consequences
	• Often lengthy wait times to see specialist
	• Patients feel fortunate to be located in Toronto where there is better access to care specialists. They recognize that it would be difficult to receive care while living in more remote areas, and thus telemedicine coverage in these areas is essential
	• The lack of communications across specialists regarding patient care may mean that the patient is responsible for the follow-up and interpretation of care decisions, which may contradict one another, leaving the patient at significant risk
Provider Access to Information	• There continues to be a lack of provider access to comprehensive and up to date patient health information, causing patients and/or caregivers to feel responsible for tracking and managing their personal health information
	• Patients worry that information will get lost in translation or be misinterpreted when they are the ones responsible for recording and repeating their story to each new care provider. There is risk of errors and omissions, which can lead to potentially wrong diagnoses and treatments
	• It is difficult for patients to understand the landscape of digital health in Ontario, such as which providers have access to specific types of digital solutions/tools, and the type of information held/shared within these. Information flows differently across and within the various health care sectors and organizations, and the patient may not know what types of information they need to share to their various providers
	• Limited provider access to real-time patient health information provides challenges to patients, including having to repeat testing and having medications prescribed that they had previously tried
Patient and/or Caregiver Access to Information	• Patients feel they should be able to access their personal health information as soon as it is available
	• Current access to patient portals does not support the needs of the patient as the information is contained within one organization and their care is not
	• If patients currently have access to their health information through a patient portal, there are still limitations to what they are able to see, such as booked appointments, high quality radiology results, etc.
Effective Communications	• Patients identified there is a lack of communication among the service providers within their circle of care to support their needs

	• Even within the same organization, there is often communication breakdowns in how care is managed and how information flows (ex. Hospital; ED to Inpatient Unit or Intensive Care Unit)
	• Patients feel there is a lack of timely communication about transition logistics, including when and how patients are transported back into the home/community. How "timely" the communication is would be dependent on the patient's ability, feelings of self-efficacy, and the availability of support. For example, some patients may need to be told to start thinking about discharge logistics a few days before they get discharged because they need their family members/caregivers to travel in order to care for them. On the other hand, if a patient lives with a family member who can be their caregiver, they may only need to plan a day in advance
	• Patients identified that there is also a lack of communication options for patients to touch base with their care providers outside of having to make an appointment
	• Some patients communicate with their care providers through email, but if they do, it is at the discretion of the care provider
Follow-up Care	• There is lack of proper coordination of follow-up care across all care sectors, leading to delays in care, duplication in care delivery, and/or lack of access to follow up care; once home, patients often feel like they have "no support"
	• Patients feel that it is their responsibility to coordinate and manage appropriate follow-up care – "always me"
	• Difficulty accessing the system in a timely way; often unsure of who to contact or what resources to refer to should follow-up care be required
Medication Management	• Patient and/or caregivers feel responsible for tracking and managing the communications around changes in their medications
	• Patients feel it is important to be able to review medications with a health care provider that understands the complexity of their health conditions. This would flag any contraindications for medications that have been prescribed by different specialists who are working in silos to deliver the patient's care plan
	• Patients often rely on pharmacists to flag any potential complications with the management of complex medications
Patient Education	• Patients feel there was often a lack of clear instructions (written or verbal) on how to manage their care when transitioning from one service provider to another, or back into the home/community. When providing information, patients would benefit more from written instructions so that they can have something to refer back to when they have to self-manage
	• Proper patient education, including knowing who to call if there are questions or unexpected symptoms, would ease anxiety and provide comfort to patients and their families

	• Patients feel like they often have to ask questions to get the information they need ("what's next?"), rather than be informed proactively through the care provider
Role of Caregiver	• Caregivers are often an unrecognized role in a patient's circle of care, yet the health care system relies on caregivers to support the facilitation of transitions in care while also provisioning care in the home
	• Caregivers often have challenges trying to access the information they need to support their family member
	• In some cases where mental health is concerned, the power of attorney for decision-making is treated differently for an adult patient with mental health issues compared to an elderly/dying patient; this may mean that the caregiver is locked out of providing essential information about the patient to a care provider, which could affect proper care and treatment
	• The cost of the caregiver's and/or patient's time and energy is not considered when appointments are made, and lengthy waits ensue
Emergency Department (ED) Experience	• Patients identified significant wait times and have experiences being assessed in the hallways due to overcrowding when visiting the ED
	• Patients had positive experiences with paramedic services and felt that they were very reassuring and informative. However, paramedics have had to wait for significant periods of time with patients in the ED due to the handover process, which takes away from the paramedic resources out on the field
	• Patients identified a lack of privacy when it comes to how patient information is verbally shared in the emergency department
	• It has been recognized that the ED is not the appropriate setting to seek care for mental health issues. However, there are not enough resources or support available outside of the ED to address this need, and thus patients feel like they have to return repeatedly to the ED for their mental health care needs

3. Patient and Caregiver Recommendations to Enable Seamless Transitions

In order to enable seamless transitions, the Toronto Central LHIN Citizens' Digital Health Working Group is putting forward recommendations for consideration based on the gaps and opportunities for improvement they identified as priority to address. Patients and caregivers identified that the breakdown that exists with transitions in care is particularly problematic when it comes to *information flow, care coordination*, and *interpersonal relationships* within the health care system*. Therefore, the priority recommendations identified are grouped in these categories and will aim to address these gaps to ensure a more seamless care experience.

While this project is centred on understanding digital health needs, it was also important to get context on the broader patient care experience to create these priority recommendations. These recommendations are intended to address specific digital health needs, as well as broader patient care issues. These recommendations are based on what may be feasible to implement in the short term in the current sector climate.

Recommendations to Leverage Digital Health to Enable Seamless Transitions

These recommendations are underpinned by the following foundational elements that are important to patients and caregivers:

- Information is needed throughout life for a patient and caregiver to manage their care
- There should be no barriers or costs to patients accessing their own health information
- Information is available in a way that is comprehensive, coherent and relevant for the patient and care providers
- Patients and caregivers want to leverage existing digital solutions where possible; unique solutions do not necessarily need to be created to address the identified issues
- Digital solutions can be effective enablers, but work is required in other areas (e.g., have integrated care teams) in order to maximize the utility of these digital solutions
- Patients and caregivers want to connect with a consistent care team who knows and understands their situation and health status. This consistency across the care pathway would help improve patient experience and outcome

Information Flow

> **RECOMMENDATION 1:**
> **Equal access to real-time health information** for all involved in the circle of care, including patients, providers, and caregivers *(if consent is provided by patient).* Work in this area should remain a priority and additional efforts should be placed on accelerating this work.

To support this recommendation, patients and caregivers provided the following feedback:
- Information is needed to understand and manage patient care, and thus should be available to all members of the care team
  - It is preferable that every patient in Ontario should have one electronic health record that integrates all personal health information within the care continuum to avoid silos of data across the health system
- Caregiver and other support system members should be able to access health information if the patient requests it

- Patients and/or caregivers should have the ability to provide updates to their own electronic health record with supporting notes, or to correct errors of fact

- Efforts to digitally enable the health and care experience should be accelerated, as this is essential to quality health care and positive outcomes. The digital landscape in health care is perceived as being significantly behind other sectors in being able to improve the experience for patients and caregivers

- Usability of the digital solutions should be considered prior to implementation. For example digital solutions that requires two-factor authentication can be difficult for patients to use. This barrier may prevent individuals and population groups who would benefit the most from the using the digital solution

RECOMMENDATION 2:
Secure two-way communications to allow for digital collaboration and virtual communication amongst those within the circle of care, including the patients as part of the care team

To support this recommendation, patients and caregivers provided the following feedback:

- Collaboration must exist within a patient's circle of care, including two-way communications between patients/or caregivers and their providers, as well as between the individual providers that are supporting patient care

- Patients and/or caregivers would like the ability to initiate communication with health service providers in circumstances where an in-person appointment may not be necessary (e.g., virtual visits, eConsult, etc.)

- Secure communication tools should include mechanisms to support individuals with accessibility issues or language barriers

Recommendations for the Broader Health System to Enable Seamless Transitions

These recommendations are underpinned by the following foundational element important to patients and caregivers:

- Patients and their caregivers must be treated as part of the circle of care, and all members must work in collaboration with each other

Care Coordination

RECOMMENDATION 3:
Integrated team-based approach to patient care to ensure managed care and collaboration amongst those within a patient's circle of care *(as defined by the patient)*

To support this recommendation, patients and caregivers provided the following feedback:

- Integrated team-based care is necessary to ensure patient-centred quality care. For team-based care to be effective, it requires trust between all the members of the care team

(which includes patient and caregiver), as well as trust in the digital solution that is being used to facilitate care. Patients need to be able to trust that the digital solution being used has robust privacy and security functionalities in place to keep their personal health information protected.

- Health service providers within and across care settings should work together in collaboration with patients and caregivers to ensure care is being delivered in a timely, coordinated, and consistent manner, with the best interest of the patient in mind

- Primary care providers should sit at the hub of the care team to manage care delivery and ensure consistency, helping ease frustrations around system navigation ("quarterback" for patients by triaging where appropriate to specialist care). Considerations should be made about having a digital hub for patients at the primary care provider level.

- Care team should collectively set care goals for patients and work collaboratively to achieve them. These care goals need to be accessible and available to all members of the care team.

Interpersonal Relationships

RECOMMENDATION 4:
Regular education for providers, patients and caregivers across the care continuum on integrated models of care to ensure that patients are seen as part of the care team

To support this recommendation, patients and caregivers provided the following feedback:

- Regular education to be provided to care providers to reinforce the culture that patients and their caregivers are part of the care team

- Support to be provided to patients and caregivers to ensure they have the power, knowledge, and ability to be a part of their own care team

  o A number of digital health solutions are currently available for patient and/or caregiver use, which could help alleviate some of the issues that they are experiencing. However, patients and/or caregivers are not aware that these exist. Efforts on disseminating information on which digital solutions are available and the purpose of each (e.g., self-management for patients with cardiac conditions, provide access to the patient's own health information) should be a priority

Proposed Next Steps for the LHINs

The LHINs should take the following next steps to address the recommendations provided by the Toronto Central LHIN Citizens' Digital Health Working Group:

1. Bring forward the recommendations to the Digital Health Advisory Council

2. Expand on the analysis provided in this summary of existing initiatives that support patient and caregiver recommendations and identify where gaps exist. Review digital health priorities with the Toronto Central LHIN Citizens' Digital Health Working Group to ensure prioritization is aligned with recommendations

3. Incorporate patient and caregiver recommendations into future strategic business planning for the LHINs

4. Provide recommended feedback around the role of the primary care provider to the group overseeing the Primary Care Strategy at the LHINs

5. Provide regular updates to the Toronto Central LHIN Citizens' Digital Health Working Group on efforts to address the patient and caregiver recommendations

Additional longer-term considerations for the LHINs:

6. The work represented here lacked input from care providers. Incorporate care providers into the discussion and involve them in the co-design to evolve the Transitions in Care Framework

7. Continue discussions to use the Transitions in Care Framework to identify needed solutions; involve patients, caregivers and care providers to take a co-design approach

Existing Initiatives that Support Recommendations

	Patient & Caregiver Recommendations				
	Information Flow			**Care Coordination**	**Interpersonal Relationships**
	Provider Access to Information	*Patient and Caregiver Access to Information*	*Secure Two-Way Communications*	*Integrated Team-Based Care*	*Relationship with Patient as Part of Care Team*
ConnectingOntario	X			X	
Electronic Care Coordination Project (eCCP)	X			X	X
eVisits	X		X		
Patient Access to Information		X			
Security Communications Package Package (SPC)	X				
Specialists and Community Services Directory (SSD)				X	

(Row label: Existing Regional Initiatives)

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World Health Organization (n.d.). *The determinants of health*: http://www.who.int/hia/evidence/doh/en/

Appendix: Detailed Project Summaries

ConnectingOntario

- **Program Summary:** ConnectingOntario is a clinical tool that provides authorized health care providers with a comprehensive view of the patient's journey through the health care system. This includes real-time access to digital health records including dispensed medications, laboratory results, hospital visits, local health integration networks home and community care services, mental health care information, and diagnostic imaging reports.
- **Impact:** As a result of ConnectingOntario, patients receive better, faster, and more coordinated health care, and providers are able to share information more effectively. Additionally, there is added benefit from improved productivity, more timely treatment, and a reduction in duplicate tests on patients, saving both time and resources. Efforts are currently underway to make it more accessible to primary care providers through the Secure Communications Package Project (description below).

Electronic Care Coordination Project (eCCP)

- **Project Summary:** The Electronic Care Coordinated Plan (eCCP) is a regional initiative providing a centralized, secure web based tool to support health service providers in collaborating, and managing Coordinated Care Plans across the Toronto Central LHIN. This improves access to integrated and quality services for Ontario's most complex population.
- **Impact:** As a result of eCCP, patients will experience better integration and more coordinated health care, and providers are able to collaborate securely and more efficiently regarding patient care plans and goals. Additional benefits include real time notifications on client progress, the centralized electronic management of CCPs will support more accurate reporting on CCPs across the region.

eVisits

- **Project Summary:** eVisits provides patients with an alternative point of access to primary care providers through secure messaging, video or voice calling. This enables patients to receive care in a timely manner by providing virtual access to care and support.
- **Impact:** As a result of eVisits, patients are able to play a more active role in their own care decisions by choosing how and where they receive care. Primary care providers can deliver the care that patients need by making health care more available closer to home through virtual care.

Patient Access to Information Project

- **Project Summary:** The Patient Access to Information pilot initiative will address the challenge of inconsistent and fragmented electronic access to personal health information by patients. The pilot will see the trial and evaluation of up to three consumer digital health solutions and evaluate the effectiveness of these solutions in meeting the challenges.
- **Impact:** The pilot will aim to improve patient access to their health information and in turn their experience with the health system, demonstrate alignment of existing digital tools, identify avenues for spread and scale of accessible digital solutions, and create standards for access to electronic personal health information to support empowerment, self-care and health literacy.

Secure Communications Package Project (SCP)

- **Project Summary:** The Secure Communications Package project streamlines and consolidates the onboarding process for a bundle of high-value digital tools, which includes ONE ID, ONE Mail, ConnectingOntario, and eConsult. Primary care physicians are then individually supported in onboarding to the new process and actively using the services.

- **Impact:** As a result of this project, primary care physicians are able to efficiently access a bundle of digital tools that provide a way to securely communicate and collaborate with other clinicians, as well as the ability to see a full view of a patient's health journey. These allow for improved patient care and efficiencies within the healthcare system.

Specialists and Community Services Directory (SSD)

- **Project Summary:** The Specialists and Community Services Directory is a regional initiative, leveraging existing provincial solutions to provide a centralized web-based Directory. It supports primary care providers in accessing the most complete and up-to-date information on specialists and community services across the Toronto Central LHIN, allowing easier patient access to these services.
- **Impact:** The Specialists and Community Services Directory intends to improve patient experience by improving access to the most suitable care and services in a timely manner. With the Directory, primary care providers will improve awareness on medical and non-medical services available for their patients, empowering them to be more involved in their own care. Additionally, specialists would receive more appropriate referrals that are better aligned with their scope of practice. This platform provides access to provincial virtual care services (e.g., eConsult, videoconference and home video visits via OTNHub) to demonstrate its scalability as a provincial asset.