

South West
LOCAL HEALTH INTEGRATION NETWORK

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du Sud-Ouest

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APPENDIX H:

Detailed Priority Action Plans

October 31, 2006

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Integration Priority & Action Plan:

Strengthening and Improving Primary Health Care

October 31, 2006



Strengthening and Improving Primary Health Care

Description

Primary health care serves a dual function in the health care system:¹

- A direct provision of first-contact services (by providers such as family physicians, nurse practitioners, pharmacists, and telephone advice lines); and
- A coordination function to ensure continuity and ease of movement across the system, so that care remains integrated when Canadians require more specialized services (with specialists or in hospitals, for example).

Health Canada suggests that primary health care services often include:²

- Prevention and treatment of common diseases and injuries;
- Basic emergency services;
- Referrals to/coordination with other levels of care (such as hospitals and specialist care);
- Primary mental health care;
- Palliative and end-of-life care;
- Health promotion;
- Healthy child development;
- Primary maternity care; and
- Rehabilitation services.

Primary health care is a cornerstone of an efficient and robust health care system. As the initial entry point to the health care system for patients and families, an integrated and comprehensive primary care system also acts as the mechanism to ensure continuity of care throughout the system. Currently, due to excessive workloads and other issues, primary care physicians often lack the information to guide patients to necessary and available resources, resulting in physicians ‘filling in’ for other skilled professionals who have more time and are more suited to providing certain types of care. These issues can be addressed through integrated and comprehensive practice primary care models that co-locate doctors, nurses, nurse practitioners, pharmacists, dietitians, social workers, health educators, mental health workers and other providers who then operate as an integrated team.

There is compelling evidence to suggest that having a strong primary care infrastructure in place can lead to improved population level health status.³ Therefore strengthening and improving access to primary care services, through better integration and coordination, is a fundamental component to creating an integrated health system to support the residents of South West LHIN.

¹ Health Council of Canada, January 2005. Health Care Renewal in Canada: Accelerating Change.

² Health Canada Website - Primary Health Care.

³ Starfield, B. and Shi, L. (2002). “Policy Relevant Determinants of Health: An International Perspective.” *Health Policy*, 60: 201-218.



A successful integrated and comprehensive primary care health system would achieve the following objectives:

- Provide equitable care as close to home as possible, regardless of age and geographic remoteness;
- Develop and strengthen innovative and flexible primary care service delivery models;
- Expand primary care services throughout the LHIN;
- Integrate and coordinate primary care services across all health care sectors for the purpose of assisting physicians to manage patients (particularly the more challenging or complex ones) more effectively and efficiently;
- Develop and implement chronic disease management clinical care pathways that maximize existing evidence-based practices and establish standardized processes in primary health care settings throughout the LHINs;
- Focus on a set of defined outcomes with appropriate performance indicators to track achievement of the outcomes;
- Incorporate innovative ways to maximize the skills of all health professionals to enable more time for delivering patient care;
- Offer programs to support health professionals in the development of effective interdisciplinary teams;
- Develop physician transition strategies to address the needs of aging or retiring physicians;
- Exploit electronic/technological tools for integration such as telemedicine, e-health, community health information networks, and video-conferencing.

Primary care must be delivered in a more integrated and comprehensive manner, regardless of the practice model used by the family physician. Thus we have included examples of potential models that can be adapted to interdisciplinary team models such as the practices that are currently encouraged by the Ministry (i.e. Family Health Teams) and to those practices that have independent or small groups of physicians. The two models are shown below and represent both situations.

Figure 1 illustrates a model for primary care physicians who practice independently, or in small groups. It is expected that this will be the predominant delivery model in the near term and thus finding innovative approaches to develop a more team-like environment is critical to success. This model tightly integrates the family physician with a case coordination role that would provide the necessary linkages to other health care providers. In this model, health care providers would not be co-located, although it would be beneficial for the case coordination function to be the primary care physician or in close proximity. It would be important to enable this model with technology, through access to a website that contains an inventory of services and access methods and/or referral forms. The double arrows indicate the two-way communication between providers and the central Primary Care Physician/Case Coordination function. In this model, communication is more difficult due to providers not being co-located and other challenges such as incompatible computer systems and the absence of close working relationships forged through face-to-face contact. Different shapes for each service provider represent different locations. In this example, the Health

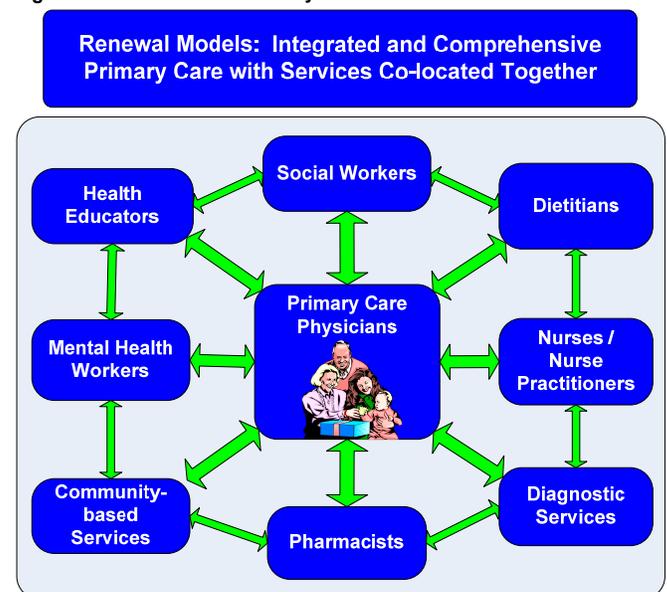
Educators and Social Workers are co-located, while all other providers work in different locations.

Figure 2 depicts primary care renewal model practices, in which health care providers are co-located within the same building or in close proximity to provide integrated and comprehensive care to patients while maximizing scope of practice of each health professional. The arrows indicate integrated communication between providers due to co-location, cohesive computer systems, and close relationships that are formed more easily when professionals work in close proximity.

Figure 1. Model for Individual and Small Group Practice Physicians



Figure 2. Model for Renewal Physicians Practices



Rationale

What our data told us:

- As of 2004, there were 723 family physicians⁴ in the South West LHIN, or 78 per 100,000 population. This is slightly below the provincial average of 84.⁵
- The overall physician supply does not tell the whole story of Family Practitioner availability throughout the South West LHIN. There are numerous areas that are designated as medically under-served. These statistics demonstrate a need for 25, 21, and 34 more GP/FPs in the North, Central, and South areas respectively.
- One important 'at risk' population that requires primary care services are residents with mental health and addiction conditions. In 2004/05, there were 5,352 acute mental health separations

⁴ Ibid.

⁵ Ontario Physician Human Resources Data Centre



and 58,862 total mental health days for South West LHIN residents. The rate of mental health hospitalizations (adjusted for age) for South West LHIN residents (5.6) was significantly higher than the rate for Ontario residents (4.5). The highest communities were in the North (6.3) and Central (7.8) portions of the LHIN. This represents 9.3% of mental health separations and 8.5% of the total mental health days for Ontario residents.

- Of the 8,258 residents requiring problem gambling and substance abuse support services, 13.7% of South West LHIN residents received their care from organizations outside their LHIN. Half reside in Middlesex County in the South portion of the LHIN.
- Approximately 39% of the South West LHIN youth in grades 7 to 12 reported cannabis use in 2005, slightly higher than the province (36%). However, 37.5% of youth reported binge drinking, which is significantly higher than that for Ontario youth overall (30.8%). Cigarette use was comparable to the province (22% vs. 20%).
- The people of the South West LHIN have socio-demographic characteristics that pose possible barriers to access to primary health care, including:
 - A significantly higher proportion of seniors when compared to the rest of Ontario;
 - A large population of people living in rural communities;
 - Lower education levels than Ontario as a whole, with a higher proportion of residents age 20+ without high school graduation. Health status improves with level of education and literacy, including self-ratings of positive health or indicators of poor health such as activity limitation or lost work days. Education increases opportunities for income and job security, and provides people with a sense of control over life circumstances — key factors that influence health. Within the South, the exception to this is the City of London where there is a higher proportion of residents with a post-secondary degree (19.5%) when compared to the province (19.2%).⁶
 - A greater proportion of people with chronic conditions than Ontario as a whole. This includes people with arthritis/rheumatism, high blood pressure, asthma, diabetes, heart disease, and chronic bronchitis.
- In the South West LHIN there are currently 41 Family Health Groups, 12 Family Health Networks; 15 Family Health Teams (FHT), 26 Comprehensive Care Model physicians⁷; two Health Service Organizations, two Community Health Centres and three developing Community Health Centres, and seven MoHLTC funded Nurse Practitioner Programs,⁸ with the latest initiative being “Grow Your Own Nurse Practitioner.”

⁶ Statistics Canada Census 2001

⁷ Comprehensive Care Model (CCM) – available to any family physician licensed to practice in Ontario, physicians agree to provide comprehensive care to their enrolled patients and are paid through a combination of fee-for-services plus monthly capitation rates, special premiums and incentives.

⁸ Nurse Practitioner Program (NP) – developed in 2002 to expand the roll of nurse practitioners in clinical settings, particularly for small, rural and under serviced areas.



Community Engagement

What we heard to inform the draft IHSP:

The first phase of community engagement included a variety of activities focused on health care providers, including a community workshop, numerous provider meetings, and a Providers Forum held in May 2006. Primary care was recognized by participants as a critical factor for the development of an integrated system in the South West LHIN. Themes from the discussions included the following:

- Create an integrated and coordinated primary care/community care system.
- Develop a model to provide comprehensive integrated care to patients who do not have a primary health care provider.
- Define the principles for a primary health care model that supports innovative, flexible services.
- Develop electronic integration strategies for primary care services such as telemedicine, e-health, community health information network, and video conferencing.
- Recognize and support “difficult to serve” patient populations, such as those with mental health and addictions conditions and/or those with multiple chronic conditions.
- Focus on development of FHTs and three emerging CHCs to ensure that outcomes are maximized, but with the understanding that only a portion of family physicians (and their patients) in South West LHIN will be included in these types of models. While there is movement toward the integration and collaboration among professionals in primary care within South West LHIN this will occur gradually over time, as physicians continue to support large practices while trying to implement change.
- Focus on access to primary care in rural settings, recognizing the need for outreach programs in remote areas.
- Integrate across all health care sectors and take into account specific communities faced with challenges of access to primary care.
- Involve physicians and other primary care groups (FHGs, FHNs, FHTs, CHCs) .

What we heard to inform the final IHSP:

The community engagement on the draft priorities of the South West LHIN included more than 65 sessions held to gain input from the public, providers, front line workers, as well as special communities such as Aboriginals and First Nations communities, the Francophone community, people affected by mental illness, and the deaf. The majority of participants were supportive of the South West LHIN’s draft priorities, and many of the same themes emerged from the discussion. Some of the comments and suggestions made by the participants included:

- The need to educate people on the broader definition of primary care which includes not only physicians but also nurse practitioners and a full range of community providers.
- The need to ensure that all roles for physicians are involved in plans (e.g. emergency room, hospitals, etc.), not just Family Health Teams.
- The need to include both Family Health Teams and traditional practice physicians.
- Recognition that mental health issues are a key challenge for the system, and a strategy to address this will require active involvement by primary care practitioners.

- Acknowledgement of the importance of partnerships and the need to build stronger connections between practitioners and opportunities for collaboration between agencies and care providers should be maximized.
- Recommendation to include a detailed review of the referral process in order to better understand referral patterns and identify opportunities.
- Acknowledgement of the central challenge of gaining the trust of physicians in the change process with a question on ‘who has influence over solo practice physicians?’
- Acknowledgement of the role of volunteers in communities to enable access to primary care.
- Examples of successful programs already underway included: Oshawa Primary Care Centre; Sauble primary care planning; Goderich nurse practitioners initiative and “no-physician clinic”.

Obstacles to Overcome: What We Heard

- **Engaging Physicians:** Influencing the behaviors of physicians and involving them in the proposed priority was identified as a significant challenge for implementation of the primary health care priority.
- **Funding and compensation structures:** Concerns about funding focused on both the need to increase the resources available for primary care, as well as the need for incentives to participate in renewal models.
- **Need for cultural change:** Participants acknowledged that system level changes would require a significant amount of cultural change among all health service providers.
- **Challenges of access:** Shortages of primary care providers in many areas was a consistent theme across the provider as well as the public engagements.
- **Information exchange:** Participants highlighted the importance of a strong technology infrastructure, or in its absence, of common communications practices.
- **Challenges for implementation:** Participants had questions about how the priority would be implemented, and how they would be kept informed about its progress.
- **Health Human Resources:** The capacity of the current system was an issue of concern for many of the participants, as well as the need to appropriately educate and recruit the next generation of providers.

Strengths to Build On:

- **What We Heard:** examples of successful primary health care programs or initiatives in the South West included:
 - Goderich has a “no-physician” clinic with nurse practitioners already in place.
 - Sauble primary care planning is already underway.
 - There are currently six Nurse Practitioners in Grey Bruce supported by the VON.
 - Grey-Bruce End of Life Program is developing models of care and measurement indicators, and palliative care teams have physician involvement.
 - Mental health partnerships such as the Mental Health Alliance of Grey Bruce have an excellent model for mild to moderate mental illness.
 - Strathroy Medical Clinic is currently developing a team practice, but additional funds are required to move forward and change the current model.

- 
- South West Medical Centre is bundling various supports in common places
 - Huron Perth nurse specialist utilization initiative in palliative care includes case consulting, referrals through several areas (i.e. not physician-specific) and specialized case manager – navigators.
 - There are hemotherapy satellites in Wingham.
 - Perth County CCAC model has strong partnerships with local long term care homes.
 - Cardiac Rehabilitation Program – Healthy Hearts (self funded through donations)
 - Healthy Sugars Program
 - Stroke and Cancer strategies are a model for networking and educating the public.
 - In other parts of the province, the Oshawa Primary Care Centre and the Wellness Program at Women’s College Hospital in Toronto are excellent models.
- **South West Network Input**
 - **South West End-of Life Network:** The network currently provides support to family physicians so that they can better serve dying patients. Experience creating and sustaining effective hospice palliative care teams that include family physicians may provide valuable lessons learned.
 - **Regional Cancer Services Alliance:** Cancer care specialists liaise on an ongoing basis with referring primary care physicians. Through the prevention and early detection, supportive care and palliative care strategies of the RCSA, steps are being taken to actively engage with primary health care providers. Plans call for the introduction of common assessment tools, introduction of a cervical screening project and continuing oncology care coordination.
 - **South West Addiction Services Network:** The South West Mental Health and Addiction Coalition was established with a mandate to provide leadership, stewardship and a unified voice for the addiction and mental health system The organization has offered to participate in and act as an information resource for the Priority Action Team.
 - **Southwestern Ontario Stroke Strategy:** The Regional Prevention Coordinator and the District Stroke Coordinators are working collaboratively to assist the Family Health Teams to include partnership with the stroke strategy in their business plans. Regional Stroke Strategy personnel can access resources to support local efforts to implement stroke best practices.

Other Relevant Evidence

Since the 1970’s, Ontario has launched primary care renewal by undertaking several initiatives to create a variety of primary care “groups”. These groups incorporate multi-disciplinary teams and payment approaches that blend traditional fee-for-service with capitation and salary options.

The characteristics of primary care physicians today are different from those of their colleagues 10 years ago.⁹ They are delivering fewer babies, and provide less hospital-based care and more psychosocial counseling. They also have increasing concerns about workload and work-life balance. In the medical profession, there is a trend away from family medicine, with less than 30%

⁹ Health Council of Canada, January 2005. Health Care Renewal in Canada: Accelerating Change.

of medical students choosing this career compared to 50% historically.¹⁰ The changing dynamics of primary care physicians further accentuates the need for new practice models that cater to the needs of family physicians and other health care professionals. The table below provides an overview of the primary care service delivery models currently in place or in the process of being formed in Ontario:¹¹

Primary Care Service Models	Description of the Model
Fee For Service	General practitioner provides patient services as an independent provider or in a group practice setting.
Family Health Group	Family Health Group (FHG) – created in 2003, is a blend of group practice family medicine at least 3 physicians come together and provide coverage for each other's patients through after-hours clinics and Telephone Health Advisory Service (THAS). Physicians are paid individually FFS for services and receive premiums for providing comprehensive care.
Family Health Network	This model contains at least 3 physicians who are providing care to a population of enrolled patients and commit to provide care to each other's patients through after-hours clinics and THAS. Payment is a blend of global capitation plus incentives. The blended payment allows the option to include allied health professionals.
Family Health Team	Family Health Teams include doctors, nurses, nurse practitioners, pharmacists, dietitians, social workers, health educators, mental health workers and other health care providers. Family Health Teams offer a range of health care services from assessing physical and mental conditions to diagnosing, treating and preventing diseases, disorders or dysfunctions. It is expected that physicians working in an interdisciplinary group practice could see significantly more patients than those working in a solo practice.
Health Service Organization	Two or more physicians working together at one site. HSO physicians have had the option of including mental health workers, dietitians, and foot care services under the Institutional Substitution funding model. HSO have been in existence since the 1970's. Patients are rostered and physicians received funding through a capitated model.
Community Health Centre	Community Health Centres (CHC) are funded through the MoHLTC. The multi disciplinary team including physicians is compensated via salary. CHC are different from the other identified models as they serve targeted, priority population groups that are known to experience barriers to accessing primary health care e.g. seniors, children / youth, people with mental health issues etc. Due to the larger number of allied health professionals involved, CHCs will have more of an impact in primary care service delivery than the models presented above.

¹⁰ Ibid.

¹¹ Adapted from "Summary of Models of Primary Care in Ontario" which cites a reference to: McCutcheon, D. & Halparin, E. "Ontario Strategies for Primary Care Reform: Them Implementation of Primary Care Reform Conference. November 2, 2003".

Overview of Action Planning

The implementation plan will include two action plans:

1. Support the evolution and development of a more connected system across primary care, by focusing on primary care renewal models and through greater awareness and connection of independent and small group family physicians to other community primary health care services.
2. Focus on improving access to comprehensive primary care with an emphasis on early intervention and wellness for people with mental health and addictions conditions as an integral component of primary health care services. Improvement will occur through the development and monitoring of clinical care paths and increased communication processes between local providers.

Performance Outcomes and Measures

These outcomes and indicators are preliminary and will be discussed and refined by the Priority Action Team. The indicators *italicized* are not represented in the Ontario Local Health System Scorecard and should be viewed as developmental until further work is complete and a determination of their ability to measure is made.

Short Term Outcomes (1 to 3 Years)	Medium Term Outcomes (4 to 5 Years)	Long Term Outcomes (6+ Years)
<ul style="list-style-type: none"> ○ Increased after-hours availability of primary health care (PHC) services ○ Increased consumer and family awareness of the availability of PHC services ○ Increase in the appropriate utilization of PHC services by consumers and their families ○ Increased linkages among physicians, patients and allied health professionals 	<ul style="list-style-type: none"> ○ Increased integration and coordination of services across physicians and allied health professionals ○ Earlier detection of emerging mental health conditions ○ Increased points of local access and service availability ○ Decreased PHC wait times ○ Increased continuity of care for people with mental health and addictions 	<ul style="list-style-type: none"> ○ Maximized scope of practice ○ Consistent application of evidence-informed practices for delivery of mental health and addictions services by all providers ○ Fully integrated service delivery across the continuum



Short Term Performance Indicators	Medium Term Performance Indicators	Long Term Performance Indicators
<ul style="list-style-type: none"> ○ Percentage of patients registered in PHC group practices visiting the ED for “non-urgent” care ○ Percentage of patients (non-rostered) visiting ED for “non-urgent” care ○ Telehealth call volume ○ <i>Team functioning score</i> ○ <i># and % of services available after-hours</i> ○ <i>Awareness indicator for consumers</i> 	<ul style="list-style-type: none"> ○ Percentage of population reporting unmet health care needs ○ Preventative screening (e.g. PAP, Mammogram) ○ Percentage of cases being treated according to Clinical Practice Guidelines (CPGs) ○ Percentage of the population reporting having a regular medical doctor (MD) ○ <i>Wait times for access to family physician</i> ○ <i>Wait times for selected procedures [e.g. mammography; colonoscopy; urology; bone density scans etc.]</i> ○ <i>Patient and provider satisfaction measure</i> 	<ul style="list-style-type: none"> ○ Readmission rates (psychiatric) ○ Potential Years of Life Lost ○ <i>Consumer/family satisfaction score</i> ○ <i>Transition measure</i> ○ <i>Team functioning score</i>



Action Plan #1

Objective

Support the evolution and development of a more connected system across primary care, by focusing on primary care renewal models and through greater awareness and connection of independent and small group family physicians to other community primary health care services.

Description

FHT and CHC organizations will offer a wider range of services and have the potential to improve access to primary care by more effectively coordinating the health professionals available within the community. However, these groups are at varying stages of development and many have not yet been established within their communities. Thus the focus here is to support and facilitate the development and implementation of these primary care teams as efficiently and effectively as possible, with full understanding of the current service offerings within each of the communities. The latter is to ensure optimal service delivery within the communities identified for these new teams.

It is unrealistic to expect a rapid shift to renewal models. As a result, there will be many primary care physicians and other providers who will continue to practice independently or in smaller, less-integrated groups. Unlike primary care reform models, traditional fee-for-service (FFS) physician practices will not have direct access to allied health staff. Consequently, linkages between physicians, their patients and other allied health care providers across sectors will require a concerted effort and significant leadership in order to ensure that residents of the LHIN receive equitable and enhanced primary care services from FFS physician offices. The implementation plan has included many of the factors necessary for successful transformation.

Deliverables – Years One to Three

Year 1 Deliverables:

- Establish a Priority Action Team (PAT) to provide leadership for the completion of the following:
 - A detailed environmental scan to identify integration opportunities for primary health care group practices with other health service providers across the continuum; and identify clinical and referral pathways that currently exist.;
 - A detailed environmental scan to create an inventory of available services from other service providers that support primary care, current utilization patterns and existing infrastructure to help communication and collaboration among primary health care partners;
 - Community engagement with physicians and allied health professionals to identify and understand what education/training strategies are needed to build team effectiveness in multi-disciplinary groups, and with the public to promote group practices and encourage rostering;

- Community engagement with consumers, the public, physicians and allied health professionals to determine how they currently interact and use these engagements as an opportunity (e.g., “working circles”) for physicians to share examples of successful processes (e.g., same-day bookings; effective interdisciplinary teams)
- Data collection across the entire LHIN regarding physician access to specialty care for their patients in terms of wait times and willingness to accept a referral;
- Analysis and the development of recommendations on:
 - Gaps in standardized pathways for primary health care;
 - Strategies to develop and disseminate these pathways;
 - Communication strategy and plan to promote group practices to the public
 - Gaps in linkages among primary care provider partners;
 - Strategies to improve linkages;
 - Communication strategies and tools to improve awareness and adopt a multi-disciplinary approach to providing primary care services for patients seeing FFS physicians; and
 - Educational sessions for primary care physicians on topics of interest.
- Quick Start #1: Enable physician “champions” who are part of primary care renewal models to speak to other physicians and medical students about the benefits of practicing in renewal models.

Year 2 Deliverables:

- Conduct detailed design and implementation planning based on the PAT’s recommendations. This will include the following:
 - Primary care clinical and referral pathways;
 - Education and training programs for multi-disciplinary teams;
 - In collaboration with University of Western, a mentorship Pilot Project for selected primary health care settings to attract new physicians into rural and remote areas as well as provide opportunities for transitional support for aging / retiring physicians;
 - Mechanisms to disseminate knowledge and understanding by physicians and patients of what services are available;
 - Systems to improve access to rapid diagnostics and test results.

Year 3 Deliverables:

- Implement detailed plans.

Performance Outcomes and Measures

The Priority Action Team will develop specific outcomes and indicators for this Action Plan building on the preliminary scorecard for the priority and the work of the Strengthening and Improving Primary Health Care Expert Panel held on October 3, 2006.



Action Plan #2

Objective

Focus on improving access to comprehensive primary care with an emphasis on early intervention and wellness for people with mental health and addictions conditions.

Description

Develop local delivery systems that focus on leveraging current partnerships but also create new partnerships to enhance coordination for early diagnosis and intervention, including:

- Identifying opportunities to create system improvements at the first point of entry into the health care system;
- Developing linkages across the different levels;
- Defining clear shared responsibility and accountability among service providers to ensure that roles and responsibilities of providers are clear so that services delivered are effective, efficient, seamless, responsive and accountable;¹²
- Addressing special age specific population recommendations.

Deliverables – Years One to Three

Year 1 Deliverables:

- Establish a cross-sectoral Priority Action Team (PAT) to lead the assessment and planning of support programs. This team will complete the following:
 - An environmental scan to create an inventory of the current scope of primary care services provided to people with mental health and addiction conditions;
 - Community engagement with primary care mental health providers and consumers in order to identify any gaps in services;
 - Analysis and recommendations to address gaps in service, improve linkages and enhance communications materials to ensure that all mental health and addictions providers and consumers are aware of current services.
- Develop intervention and assessment strategies and tools for primary care physicians to support effective early screening of mental health and addictions conditions.
- Assess shared-care model opportunities that will improve access to patient services and build partnerships (e.g. London-Middlesex Collaborative Mental Health Care), identify early wins, and conduct pilot studies.
- Quick Start #1: Engage in cross-jurisdictional discussions with mental health alliances to implement best practices incrementally for supporting at risk populations (e.g., London enforcement providing mental health support services for women in the sex trade).

¹² The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario. Final Report of the Provincial Forum of Mental Health Implementation Task Force Chairs. 2002.



Year 2 Deliverables

- Conduct detailed design and implementation planning based on the recommendations from the PAT. These plans will include:
 - The development of prioritized implementation plans for each selected option;
 - Piloting of shared care models throughout the LHIN (target different models for different selected offices);
 - Monitoring and reporting systems to measure success in the expanded services;
 - Initiatives to educate/orient the primary care provider community on available options and services and the process to access them for their patients.

Year 3 Deliverables

- Implement detailed plans.

Performance Outcomes and Measures

The Priority Action Team will develop specific outcomes and indicators for this Action Plan building on the preliminary scorecard for the priority and the work of the Strengthening and Improving Primary Health Care Expert Panel held on October 3, 2006.