South West LHIN
Primary Health Care Capacity Report
Draft Recommendations

West Elgin Community Health Centre and the South West LHIN jointly sponsored a study called *Understanding Health Inequities and Access to Primary Care in the South West LHIN* to gain a better understanding of the needs of those facing multiple barriers to accessing health care and the changing demographics of both the general population and the primary care providers.

To accomplish this, several phases of research were conducted: (1) a literature review focusing on access and barriers to primary care, (2) geospatial and geostatistical analysis of the South West LHIN, (3) surveys of the population and health care providers to validate collected data and address gaps, and (4) focus groups to collect peoples' lived experiences in accessing primary care.

The following key questions guided the research:

1. How closely do primary care services in the South West LHIN meet the needs of the population based on the social determinants of health?
2. What does the evidence tell us about how the spectrum of social determinants of health that people experience effect their primary care needs?
3. How do the social determinants of health measures correlate with health service use (as a proxy of health service need)?

The research focused on five specific vulnerable groups: i) Indigenous people; ii) ethno-cultural groups and recent immigrants; iii) rural residents; iv) people with low socioeconomic status; and v) seniors. It is important to note that this is not an exhaustive list, as other vulnerable populations such as the homeless, and LGBTQ* and old order Mennonite and Amish populations live in our region, but there is a lack of existing data, and small populations make these groups difficult to examine, although some lived experience data about the old order Mennonite and Amish populations has been included.

The development of these recommendation also included the review of several earlier reports on primary care needs Indigenous people and people experiencing mental health and addictions.

This research and report have been informed by the following recommendations that also support equitable access to primary care for individuals most impacted by the social determinants of health in the South West LHIN.

- *Aboriginal Data Report for the South West LHIN Health Links*
- *Aboriginal Diabetes in South West Ontario: Winning the Fight Against Diabetes*
- *Aboriginal Patient Journeys: Telling Our Stories*
- *Aboriginal Education & Training Capacity*

(** = recommendations in this report that align with recommendations contained in the above 4 reports

- *Mental Health Community Capacity Report (2014)*
- *The Time is Now: Mental Health and Addictions Community Capacity Report (2011)*

(* = recommendations in this report that align with recommendations contained in the above 2 reports

For the purposes of these recommendations, the following definitions have been used:

PCP = Primary Care Provider and is limited to family physicians/primary care physicians who provide comprehensive primary care working in any primary care model **and** Nurse Practitioners working in Nurse Practitioner Led Clinics
FP = Family physician/primary care physician who provides comprehensive primary care working in any primary care model
NP = Nurse Practitioner and is limited to NPs in a nurse practitioner led clinic providing primary care. This limitation is due to lack of data about the roles of NPs in other primary care setting.
NPLC = Nurse Practitioner Led Clinic
IHP = Interdisciplinary health professionals working in a primary care model
FHT = Family Health Team which is a primary health care organizations that include a team of family physicians, nurse practitioners, registered nurses, social workers, dietitians, and other professionals who work together to provide primary health care for their community
CHC = Community Health Centre which is a primary health care organization that delivers primary care services in combination with health promotion and illness prevention services that address the social determinants of health that negatively impact people's health.
LHIN = South West Local Health Integration Network

Recommendation #1:
Every person in the South West LHIN will have access to culturally safe primary care, regardless of their culture, economic status or where they live, that is provided by primary care providers who have the necessary knowledge and skills to communicate with patients such that the patients feel respected and receive information that they can understand and act on to improve their health.**

#	Action
1.1	Increase the enrollment of PCPs in Southwest Self-Management education programs to support the improvement of patient experience with primary care practices.**
1.2	Work with Southwest Self-Management program to develop curriculums to improve patient experience with an equity lens in primary care practices. Leverage sub-region clinical leadership to promote / implement.**
1.3	Incorporate an Experienced Based Design (EBD) approach to strategically maximize the potential for thehealthline.ca to be an effective tool to communicate patients' rights and responsibilities when accessing primary care as well as patient and provider education around visit expectations.**
1.4	In partnership with the Aboriginal Health Committee and local Indigenous health care providers, the LHIN, physician leaders and Health Service Providers (HSP) will work to improve access to culturally safe primary care by supporting/participating in the implementation of recommendations for primary care contained in the following reports: • Aboriginal Data Report for the South West LHIN Health Links • Aboriginal Diabetes in South West Ontario: Winning the Fight Against Diabetes

#	Action
	• Aboriginal Patient Journeys: Telling Our Stories • Aboriginal Education & Training Capacity
1.5	In partnership with the Aboriginal Health Committee and local Indigenous health providers, the LHIN, HSPs and primary care need to increase understanding and application of treaty rights and obligations to achieve optimal primary care for the Indigenous population.
1.6	The LHIN will ensure Indigenous Cultural Safety Training spots are available to all primary care providers and promote the training.**
1.7	To enable LHIN wide population health planning, encourage and support HSPs and PCPs, through the use of available Quality Improvement (QI) resources, to collect and report data related to equity/vulnerable groups and where feasible include marginalized populations not included in the original analysis such as LGBTQ, homeless, Amish/Mennonite and migrant farm workers. **
1.8	In partnership with the South West LHIN Primary Care Network, Ontario College of Family Physicians, Ontario Medical Association, Department of Family Medicine, Schulich School of Medicine and Dentistry, the LHIN will create a venue to provide education opportunities for primary care providers on mental health and addictions supports, victims of violence, abuse and trauma, poverty screening tool (OCFP), Indigenous Cultural Safety Training.**
1.9	To reduce inequitable access to transportation services across the LHIN, the Community Support Services Network will be leveraged to define specific provider and public strategies to promote understanding of transportation services that are available and promote and understand available financial resources to support people's ability to pay.
1.10	Develop partnerships with local public health units and other local health promotion bodies to leverage and support the incorporation of health promotion activities that target those most affected by the social determinants of health across sectors within sub-region planning.
1.11	The LHIN will work to inform process changes that support patient choice e.g. with Health Care Connect people currently needing to be 'orphaned' in order to be on the list.
1.12	Develop processes or mechanisms to connect people to the PCP of their choice or to services and resources in their language of their choice (e.g. French-speaking person to French-speaking PCP, translating thehealthline.ca into different languages).
1.13	In partnership with PCPs develop and provide targeted education for primary care practices to increase equity sensitivity: • Interpretation services • Cultural / Religious sensitivity • Culturally safe care approaches e.g. Indigenous Cultural Safety Training** • Patient choice/preference**
1.14	**GB:** Link to Health Link Health Equity Impact Assessment (HEIA) recommendations for Amish and Mennonite population to deepen understanding of how to provide culturally safe care.
1.15	**HP:** Link to Health Link HEIA recommendations for Amish and Mennonite population to deepen understanding of how to provide culturally safe care.
1.16	**LM:** In partnership with PCP leadership, create mechanisms to inform and update PCPs about resources available to support optimal primary care for ethno-cultural groups and support the integration of these resources into their practice.
1.17	**Elg:** Deepen the understanding of how to provide culturally safe care (link to Health Link HEIA where appropriate) for Amish, Mennonite and migrant farm worker populations.

Recommendation #2:
Every person in the South West LHIN will have timely access to primary care including same day, next day, planned visits and after hours care.

#	Action
2.1	The LHIN will engage with hospitals, FPs and patients to understand when and why FPs see their patients in the emergency department (ED) for visits that could be treated in primary care settings. Understand what the ED coding rules and practices are for these visits. This will allow the LHIN to determine where practices can be influenced for optimal primary care delivery and plan accordingly.
2.2	The LHIN will work with CHCs to maximize their hours of coverage.
2.3	In partnership with provincial primary care leadership including associations (OMA, OCFP, CPSO, AFHTO, NPAO, AOHC[1]): • Work with FPs in patient enrollment models and NPLCs to optimize their after-hours clinics. • Work with FPs, CHCs, FHTs and NPLCs to optimize access to primary care including after-hours care. • Develop a process that encourages and supports PCPs to accept unattached people. • Develop a process to ensure unattached patients presenting in the ED are identified and linked with a primary care provider.
2.4	Move Advanced Access forward in primary care practices by: • Connecting good pockets of practice through physician leadership in the LHIN • Understanding barriers to wider implementation • Utilizing resources like Partnering for Quality, Clinical Quality Table, Experience Based Design to get a clearer picture
2.5	**HP**: Leverage the understanding of ED use by FPs (recommendation 1.1) to develop a local strategy to ensure patients receive care in the most appropriate setting.
2.6	**LM**: In partnership with local and provincial primary care leadership including associations (OMA, OCFP, CPSO, AFHTO, NPAO, AOHC) develop a process to attach unattached people who regularly access walk in clinics.

Recommendation #3:
To support the provision of optimal (quality) primary care, all primary care providers must have access to timely, consistent, effective wrap-around patient services (in office or virtual) aligned with need.

#	Action
3.1	In partnership with provincial and local primary care leadership including associations (e.g. AOHC, AFHTO, NPAO) and other health provider partners, explore alternative service delivery models for primary care within team- based care to increase accessibility and effective system navigation (e.g. fast track clinic with NPs, flex clinic, home visits, Emergency Medical Service (EMS) pilots, in-home IV, technology enabled remote connections, Coordinated Care Plans).

[1] OMA – Ontario Medical Association OCFP – Ontario College of Family Physicians CPSO – College of Physicians and Surgeons of Ontario AFHTO – Association of Family Health Teams of Ontario NPAO –Nurse Practitioners' Association of Ontario AOHC – Association of Ontario Health Centres

#	Action
3.2	Ensure sub-region planning considers the availability of flex clinics or urgent care clinics to reduce unnecessary hospital use.
3.3	Sub-region planning to incorporate an EBD approach to understand and address the immediate pressures of primary care providers who currently do not have access to IHPs trying to access interdisciplinary health or specialist care for their patients (e.g. SCOPE project in Toronto).
3.4	The LHIN will develop mechanisms to increase accountability of health service providers to integrate their services with primary care to ensure the establishment of stronger relationships and coordination of services that supports best patient experience of care.
3.5	The LHIN will continue to support the South West Addictions and Mental Health Coalition and primary care leadership to implement the recommendations from the *Mental Health Community Capacity Report (2014) and The Time is Now: Mental Health and Addictions Community Capacity Report (2011)* and align this work with sub-region planning.
3.6	Mental health and addiction (MH&A) providers and PCPs will take a coordinated approach to maximize access to and utilization of sessional fees for psychiatric services.*
3.7	Ensure sub-region planning leverages virtual team models as described in the Vision 2022 Blueprint to support the integration of primary care with wrap-around services.
3.8	Every vulnerable person that would benefit from and be supported by a Coordinated Care Planning approach will be identified and offered a Coordinated Care Plan that includes the consideration of the social determinants of health.*
3.9	The LHIN physician leadership in partnership with local MH&A providers will bring psychiatrists, focused practice mental health FPs, PCPs and MH&A providers together to talk about programs to support PCPs to support patients with mental health and addictions needs (e.g. Bounce back – Central and TC LHINs, Elgin example, OCFP mentorship, ECHO).*
3.10	Work with the LHIN Internal Medicine Lead to influence specialists' comfort in accepting referrals from NPs.*
311	Promote the South West LHIN Specialist Directory to primary care providers to increase understanding of specialist resources available in the region.*
3.12	**GB**: With an emphasis on people with complex needs, in North Grey Bruce, partner solo practice physicians with existing community services to support greater wrap around care for their patients (eg. CCAC, Canadian Mental Health Association, Diabetes Education Programs, Health Links, People in Need of Teams (PINOT) model.*
3.13	**GB**: Partner with ED staff, PCPs and community care providers to co-create processes to optimize use of home and community care resources to reduce unnecessary hospital use (e.g. wound care, ultrasound, IV starts or antibiotics, flex clinics).
3.14	**HP**: Engage FHT executive directors to work collaboratively to address gaps in access to team based primary care in Huron Perth (e.g., Mitchell, and Exeter).
3.15	**HP**: Partner with ED staff, PCPs and community care providers to co-create processes to optimize use of home and community care resources to reduce unnecessary hospital use (e.g. wound care, ultrasound, IV starts or antibiotics, flex clinics).
3.16	**LM**: Partner all primary care providers who currently do not have access to publically funded IHPs with resources needed to support more complex / vulnerable patients (e.g. PINOT model).
3.17	**OX**: Partner all primary care providers who currently do not have access to publically funded IHPs with resources needed to support more complex / vulnerable patients (e.g. PINOT model).
3.18	**Elg**: Partner all primary care providers who currently do not have access to publically funded IHPs with resources needed to support more complex / vulnerable patients (e.g. PINOT model).

Recommendation #4:

Timely, quality primary care will be available to people in the South West LHIN by ensuring the right mix and distribution of primary health care providers throughout the region.

#	Action
4.1	Apply an equity lens to support strategic recruitment of primary care resources: • Through the Managed Entry Process to support areas of high need identified in this report. Where possible target or influence recruitment to address identified gaps for ethno-cultural groups and the Indigenous population. • When planning for future fluctuations in provider availability.
4.2	Health Force Ontario (HFO) in partnership with the LHIN and other key stakeholders will create an orientation for all primary care providers prioritizing new primary care providers to expedite and enhance their understanding of patient and provider resources available and facilitate ease of referral and collaboration.
4.3	Create a multi-pronged approach to support PCPs and IHPs to work to their optimal scope of practice such as: • Education to support role clarity • Support PCPs and IHPs to use a QI approach
4.4	A mechanism will be identified to ensure all new FPs are identified and supported by orientation processes in our region.
4.5	The LHIN will develop a transparent and repeatable process to identify communities of high primary care need leveraging data and information from this process, HFO, and the MOHLTC.
4.6	**GB**: Identify and support strategies to increase the number of culturally safe primary care providers to support the Indigenous population.
4.7	**HP:** HFO to engage FHT executive directors and Family Health Network/Family Health Organization physician leads to work collaboratively to optimize establishment of a family physician in Brussels to enable patients to have access to physician closer to home.
4.8	**LM:** Include London in the managed entry areas of high physician needs for specific postal codes to be identified by FSA[2] attachment rate data.
4.9	**LM**: Identify and support strategies to increase capacity to provide culturally safe primary care to support the Indigenous population specifically in Strathroy.
4.10	**LM:** HFO and the LHIN will meet with City of London officials and ethno-cultural groups to educate on gaps that could be addressed through targeted recruitment.
4.11	**LM:** LHIN will identifies strategies to ensure more competitive physician compensation in order to attract and retain physicians to support London InterCommunity Health Centre to reach full complement.
4.12	**OX:** Work with local stakeholders to determine and recruit to the best primary care model to address both general FP coverage for low PCP access areas and vulnerable populations in Tillsonburg, Woodstock, South-West Oxford and Norwich.
4.13	**OX:** Support additional CHC physician resources to address both general FP coverage for low PCP access areas and targeted at the vulnerable populations in Tillsonburg, Woodstock, South-West Oxford and Norwich.
4.14	**Elg:** Support targeted recruitment to address both general FP coverage for low PCP access areas and targeted at the vulnerable populations in south east Elgin.
4.15	**Elg:** Work with local stakeholders to determine and recruit to the best primary care model to address risk of potential retirements where 1:1 replacement is insufficient.

[2] FSA - Forward sortation area which is a geographical region in which all **postal codes** start with the same three characters

#	Action
4.16	**Elg:** Identify and support strategies to increase capacity to provide culturally safe primary care to support the Indigenous population specifically in Dutton and West Lorne areas.
4.17	**Elg:** Explore various FP to NP ratios in CHCs to support optimal use of primary care resources to meet patient needs. This may also include identifying strategies to support transitioning Fee for Service PCPs to the best primary care model to address the community's needs.

Recommendation #5:

Primary care providers will have access to shared information on patients including real time data and resources available to enable them manage the health of the population and work collaboratively with other health care providers in the provision of seamless care and services for their patients.

#	Action
5.1	In the sub-regions, leverage LHIN physician lead resources to ensure all PCPs are aware of information technologies available to maximize the multi-directional flow of information.
5.2	Provide coaching and support to all PCPs through such supports as cSWO, Partnering for Quality (PFQ), and Quality Improvement Decision Support Specialist (QIDSS) to optimize use of information technologies to support integration of information for shared patients.
5.3	The LHIN will enhance the number of PFQ resources to support QI and Electronic Medical Record (EMR) optimization.
5.4	Align the efforts of QI resources in the region including PFQ, QIDDS, OntarioMD, Health Quality Ontario (HQO), QI specialists, Health Link QI coaches, CHC QI resources, LHIN QI resources and the Regional Clinical Quality Table to optimize the collective impact on population health.
5.5	Spread the St. Thomas Elgin General Hospital IDEAS project model to other hospitals in the LHIN to ensure visits to primary care providers after hospital discharge: • Focus on processes with shared information/notification. • Connect patients with PCP before they leave the hospital (managing transitions of care) including those that live out of area.
5.6	Work with PCPs and hospital partners to apply/spread e-Notification across primary care practices so all PCPs know when their patients have had a hospital admission or ED visit.
5.7	Leverage practice reports, future equity data and real time data as well as other resources like Integrated Decision Support (IDS), QIDDS, PFQ, Data to Decision (D2D), Choosing Wisely to reinforce their use to inform practice improvement as it relates to equity, complexity and outcomes.
5.8	Redesign, leveraging an EBD approach, thehealthline.ca to be the place for providers and patients to connect to the health care system in the South West LHIN.