South West LHIN
Primary Health Care Capacity Report
Final 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 the 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 informed the following recommendations that 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
GB = Grey Bruce sub-region
HP = Huron Perth sub-region
LM = London Middlesex sub-region
ELG = Elgin sub-region
OX = Oxford sub-region

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. This will be achieved by:**

#	Action
1.1	Increasing the enrollment of PCPs in Southwest Self-Management education programs to support the improvement of patient experience with primary care practices.**
1.2	Working with the Southwest Self-Management program to develop curriculums to improve patient experience with an equity lens in primary care practices. Leveraging sub-region clinical leadership to promote/implement.**
1.3	Incorporating 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.**

#	Action
1.4	Partnering with the Aboriginal Health Committee, local Indigenous health care providers, the LHIN, physician leaders and Health Service Providers (HSP) 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 • Aboriginal Patient Journeys: Telling Our Stories • Aboriginal Education & Training Capacity
1.5	Partnering with the Aboriginal Health Committee, and local Indigenous health providers to increase understanding and application of treaty rights and obligations by the LHIN, HSPs and primary care to achieve optimal primary care for the Indigenous population.
1.6	Ensuring Indigenous Cultural Safety Training spots are available to all primary care providers, by promoting the training and monitoring participation.**
1.7	Enabling LHIN-wide population health planning, encouraging and supporting 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 including marginalized populations not included in the original analysis such as LGBTQ, homeless, Amish/Mennonite and migrant farm workers.**
1.8	Building capacity in the system for PCPs to support patients with mental health and addictions, victims of violence, abuse and trauma, living in poverty and Indigenous people by creating a venue to provide education opportunities in partnership with the South West LHIN Primary Care Network, Ontario College of Family Physicians, Ontario Medical Association, Department of Family Medicine, and Schulich School of Medicine and Dentistry.**
1.9	Reducing inequitable access to transportation services across the LHIN, by leveraging the Community Support Services to define specific provider and public strategies to promote understanding of transportation services that are available. Understanding and promoting available financial resources to support people's ability to pay to maximize the use of available resources.
1.10	Developing 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	Informing 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	Developing processes or mechanisms to connect people to the PCP of their choice or to services and resources in their language of choice (e.g. French-speaking person to French-speaking PCP, translating thehealthline.ca into different languages).
1.13	Partnering with PCPs to 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**

#	Action
	• Patient choice/preference**
1.14	**GB:** Linking to Health Link Health Equity Impact Assessment (HEIA) recommendations for Amish and Mennonite populations to deepen understanding of how to provide culturally safe care.
1.15	**HP:** Linking to Health Link HEIA recommendations for Amish and Mennonite populations to deepen understanding of how to provide culturally safe care.
1.16	**LM:** Partnering with PCP leadership to 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:** Deepening 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. This will be achieved by:

#	Action
2.1	Engaging with hospitals, FPs and patients to understand when and why patients are seen in the emergency department (ED) for planned and unplanned visits that could be treated in primary care settings to enable the LHIN to determine where practices can be influenced for optimal primary and ED care delivery and plan accordingly.
2.2	Partnering 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.
2.3	Moving 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 (EBD) to get a clearer picture of the current state.

[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
2.4	**HP**: Leveraging 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.
2.5	**LM**: Partnering with local and provincial primary care leadership, including associations (OMA, OCFP, CPSO, AFHTO, NPAO, AOHC) to 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 PCPs must have access to timely, consistent, effective wrap-around patient services (in office or virtual) aligned with need. This will be achieved by:

#	Action
3.1	Partnering with provincial and local primary care leadership including associations (e.g. AOHC, AFHTO, NPAO) and other health provider partners to 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).
3.2	Ensuring sub-region planning considers the availability of flex clinics or urgent care clinics to reduce unnecessary hospital use.
3.3	Utilizing an EBD approach to understand and address the immediate pressures of PCPs who currently do not have access to IHPs but would like to access interdisciplinary health or specialist care for their patients (e.g. SCOPE project in Toronto).
3.4	Developing 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	Supporting 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 as it aligns with Patients First.
3.6	Coordinating an approach with mental health and addiction (MH&A) providers and PCPs to maximize access to and utilization of sessional fees for psychiatric services.*
3.7	Ensuring 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	Identifying and offering a Coordinated Care Plan to every vulnerable person that would benefit from and be supported by a Coordinated Care Planning approach that includes the consideration of the social determinants of health.*
3.9	Partnering with local MH&A providers, the LHIN physician leadership 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).*

#	Action
3.10	Working with the LHIN Internal Medicine Lead to influence specialists' comfort in accepting referrals from NPs.*
3.11	Promoting the South West LHIN Specialist Directory to PCPs to increase awareness of specialist resources available in the region.*
3.12	**GB**: Partnering solo practice physicians with existing community services to support greater wrap around care for their patients (e.g. CCAC, Canadian Mental Health Association, Diabetes Education Programs, Health Links, People in Need of Teams (PINOT) model) with an emphasis on people with complex needs, in North Grey Bruce.*
3.13	**GB**: Partnering 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**: Engaging 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**: Partnering 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**: Partnering all PCPs who do not currently have access to publically funded IHPs with resources needed to support more complex/vulnerable patients (e.g. PINOT model).
3.17	**OX**: Partnering all PCPs who do not currently have access to publically funded IHPs with resources needed to support more complex/vulnerable patients (e.g. PINOT model).
3.18	**ELG**: Partnering all PCPs who do not currently 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. This will be achieved by:

#	Action
4.1	Applying 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	Creating an orientation for all primary care providers in partnership with Health Force Ontario (HFO) and other key stakeholders prioritizing new primary care providers to expedite and enhance their understanding of patient and provider resources available and facilitate ease of referral and collaboration.

#	Action
4.3	Creating 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	Identifying a mechanism to ensure all new FPs are identified and supported by orientation processes in our region.
4.5	Developing 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**: Identifying and supporting strategies to increase the number of culturally safe primary care providers to support the Indigenous population.
4.7	**HP:** Engaging with 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:** Including 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**: Identifying and supporting strategies to increase capacity to provide culturally safe primary care to support the Indigenous population specifically in Strathroy.
4.10	**LM:** Meeting with City of London officials and ethno-cultural groups to educate them on gaps that could be addressed through targeted recruitment.
4.11	**LM:** Identifying 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:** Working 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:** Supporting 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:** Supporting 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:** Working 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.
4.16	**ELG:** Identifying and supporting 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:** Exploring 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.

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

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. This will be achieved by:

#	Action
5.1	Leveraging LHIN physician lead resources in the sub-regions to ensure all PCPs are aware of information technologies available to maximize the multi-directional flow of information (e.g. eConsult, HRM, Clinical Connect).
5.2	Providing coaching and support to all PCPs through such supports as cSWO, Partnering for Quality (PFQ), and Quality Improvement Decision Support Specialists (QIDSS) to optimize use of information technologies to support integration of information for shared patients.
5.3	Enhancing the number of PFQ resources to support QI and Electronic Medical Record (EMR) optimization.
5.4	Aligning 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	Spreading 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	Working 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	Leveraging practice reports, future equity data and real time data as well as other resources like Integrated Decision Support (IDS), QIDSS, PFQ, Data to Decision (D2D) and Choosing Wisely to reinforce their use to inform practice improvement as it relates to equity, complexity and outcomes.
5.8	Redesigning thehealthline.ca, by leveraging an EBD approach, to be the place for providers and patients to connect to the health care system in the South West LHIN.